TEXAS REGISTER

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Maegan Reichert

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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IN THIS ISSUE

THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Appointments

Appointments for November 16, 2005

Appointed as Judge of the 257th Judicial District Court, Harris County, for a term until the next General Election and until her successor shall be duly elected and qualified, Judy Lynn Warne of Houston. Ms. Warne is replacing Judge Linda Motheral who resigned.

Appointing as Presiding Judge of the Eighth Administrative Judicial Region for a term to expire four years from date of qualification, Roger Jeffrey Walker of Arlington. Judge Walker is being reappointed.

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Patricia Alvarez of Austin (replacing Amy Sue Patrick of Valley View who resigned).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Ramona Diane Cardenas (Ex-Officio Member) of San Antonio (replacing John Weeks of Midland whose term expired.

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Cindy S. Miller of Garden Ridge (replacing Anne Brown of Dallas whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Tobin Richard Boenig of Austin (replacing Susan Blue of Fort Worth whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Dwayne W. Horner of Dallas (replacing Louisa Kluger of Houston whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2007, Shawn Patrick Saladin of Austin (replacing Leo Ramos of San Antonio whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Brenda Lynn Dunn (Ex-Officio Member) of Austin (pursuant to 29 U.S.C., §725(b); Human Resources Code, §111.016).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Paula Jean Margeson of Plano (pursuant to 29 U.S.C., §725(b); Human Resources Code, §111.016).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Corbett Chase Bearden of Austin (replacing Mario David Gonzales of Houston whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Joseph F. Acosta, Jr. of El Paso (replacing Susan Junek of Caldwell whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Richard P. Poe of Austin (replacing Susan Rose of Austin whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2008, Richard Giles Hatfield of Austin (replacing Robert Hawkins of Bellmead whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2009, Roy Larry Evans of San Angelo (replacing Sharon Miller of Austin whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2009, Carol C. Edwards of Conroe (replacing Donald Weng of San Antonio whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2009, Mike Halligan of Georgetown (replacing Ettalois Johnson of Houston whose term expired).

Appointed to the Rehabilitation Council of Texas for a term to expire October 29, 2009, William F. Mullican, III of Austin (replacing Malisa Janes of Houston whose term expired).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Margaret Hasse Cowen of San Antonio (Ms. Cowen is being reappointed).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Richard E. Garnett, Ph.D. of Fort Worth (Dr. Garnett is being reappointed).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Donna Nelson Geiger of Austin (pursuant to Human Resources Code §114.003).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Anna Penn Hundley of Dallas (replacing Lora Bennett of Austin whose term expired).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Opal Irvin of Dimebox (Ms. Irvin is being reappointed).

Appointed to the Texas Council on Autism and Pervasive Developmental Disorders for a term to expire February 1, 2007, Frank Christian McCamant of Austin (replacing Patrick Herndon, M.D. of Spicewood whose term expired).

TRD-200505462

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THE ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code, Title 4, §402.042, and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open records decisions are summarized for publication in the *Texas Register*. The attorney general responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the attorney general unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. You may view copies of opinions at http://www.oag.state.tx.us. To request copies of opinions, please fax your request to (512) 462-0548 or call (512) 936-1730. To inquire about pending requests for opinions, phone (512) 463-2110.

Request for Opinions

RQ-0411-GA

Requestor:

The Honorable Todd Staples

Chair, Committee on Transportation and Homeland Security

Texas State Senate

Post Office Box 12068

Austin, Texas 78711

Re: Whether a city-owned utility may set payment deadlines and assess penalties against another governmental body (RQ-0411-GA)

Briefs requested by December 16, 2005

RQ-0412-GA

Requestor:

The Honorable Mark E. Price

San Jacinto County Criminal District Attorney

1 State Highway 150, Room 21

Coldspring, Texas 77331-0430

Re: Authority of a county to remove an abandoned mobile home from county right-of-way (RQ-0412-GA)

Briefs requested by December 16, 2005

RQ-0413-GA

Requestor:

Mr. C. Tom Clowe Jr., Chair

Texas Lottery Commission

Post Office Box 16630

Austin, Texas 78761-6630

Re: Authority of the Texas Lottery Commission to adopt a rule permitting on-line games (RQ-0413-GA)

Briefs requested by December 18, 2005

RQ-0414-GA

Requestor:

The Honorable Robert E. Talton

Chair, Committee on Urban Affairs

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether a home-rule city must comply with certain provisions of chapter 102, Local Government Code, regarding the city budget (RQ-0414-GA)

Briefs requested by December 18, 2005

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200505442
Stacey Schiff
Deputy Attorney General
Office of the Attorney General
Filed: November 22, 2005

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Opinions

Opinion No. GA-0375

The Honorable Rex Emerson

Kerr County Attorney

700 Main Street, Suite BA-103

Kerrville, Texas 78028

Re: Whether section 6.05(f) of the Tax Code bars the continued employment of a county appraisal district employee after the employee marries the same county's tax assessor-collector (RQ-0346-GA)

S U M M A R Y

Section 6.035(a)(1) of the Tax Code, which directs that an individual is ineligible to serve on an appraisal district board of directors if the individual is married "to an individual who is engaged in the business of appraising property for compensation for use in proceedings under this title," applies to a tax assessor-collector who serves as a nonvoting member of the board of directors under section 6.03(a) of the same code. TEX. TAX CODE ANN. §6.035(a)(1) (Vernon 2001); *see also*

id. §6.03(a) (Vernon Supp. 2005). Similarly, section 6.05(f) of the Tax Code, which prohibits a chief appraiser from employing the spouse of "a member of the board of directors" applies to a tax assessor-collector who serves as a nonvoting member of the board of directors under section 6.03(a). *Id.* §6.05(f) (Vernon 2001).

Nevertheless, section 6.035(a) does not apply when an appraisal district board member is married to an employee of the appraisal district. The words in section 6.035(a), "is engaged in the business of appraising property for compensation for use in proceedings under this title," *id.* §6.035(a)(1), refer to an individual who appraises property for commercial profit. Consequently, a tax assessor-collector is eligible to serve as a nonvoting member of the appraisal district board of directors under 6.03(a) despite her marriage to an appraisal district employee.

If the chief appraiser employs the spouse of the local tax-assessor collector, who serves as a member of the appraisal district board, the chief appraiser violates section 6.05(f). The continuous- employment exception to the general anti-nepotism statute, found in Government Code chapter 573, does not apply to section 6.05(f) of the Tax Code. *See* TEX. GOVT CODE ANN. §§573.041, .062(a) (Vernon 2004). Consequently, upon an appraisal district employee's marriage to the tax assessor-collector, the appraisal district cannot continue to employ him. The employee may retain his employment either until the end of his contract with the appraisal district, or if the employee is employed at-will, he may retain his employment until the end of the pay period during which his marriage occurs.

The tax assessor-collector has no authority to either decline to serve as a nonvoting member of the appraisal district board of directors under Tax Code section 6.03(a) or to appoint an agent from her office to serve in her stead.

Opinion No. GA-0376

The Honorable Leticia Van de Putte, R.Ph.

Chair, Committee on Veteran Affairs and Military Installations

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Whether the Texas Workforce Commission is prohibited from using block grants to fund programs listed under section 302.062(g) of the Labor Code (RQ-0347-GA)

S U M M A R Y

Section 302.062(a) of the Labor Code generally requires the Texas Workforce Commission to fund workforce training and employment services with block grants to local areas. Section 302.062(g) of the Labor Code exempts certain programs from that mandatory requirement but does not prohibit the Commission from funding the listed programs by distributing block grants to local areas. Whether the Commission may fund a particular program listed in section 302.062(g) by block grants to local workforce areas must be determined on the basis of laws governing the particular program, in light of the Commission's general duty to consolidate programs and to ensure that workforce development services are planned and delivered at the local level.

For further information, please access the website at www.oag.state.tx.us. or call the Opinion Committee at 512/463-2110.

TRD-200505444
Stacey Schiff
Deputy Attorney General
Office of the Attorney General
Filed: November 22, 2005

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PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 1. ADMINISTRATION

PART 2. TEXAS ETHICS COMMISSION

CHAPTER 6. ORGANIZATION AND ADMINISTRATION

SUBCHAPTER A. GENERAL RULES

1 TAC §6.5

The Texas Ethics Commission proposes an amendment to §6.5, relating to the authority of the Texas Ethics Commission to adopt rules.

Section 6.5 amends the rule that establishes the Ethics Commission's authority to adopt rules. The amendment would prohibit the commission from adopting a rule that in the opinion of the commission directly addresses the subject matter of pending litigation known to the commission.

David A. Reisman, Executive Director, has determined that for each year of the first five years the rule is in effect there will be no fiscal implication for the state and no fiscal implication for local government as a result of enforcing or administering the rule as proposed. Mr. Reisman has also determined that this rule will have no local employment impact.

Mr. Reisman has also determined that for each year of the first five years the rule is in effect, the anticipated public benefit will be consistency in the manner in which the commission addresses issues related to pending litigation known to the commission.

Mr. Reisman has also determined there will be no direct adverse effect on small businesses or micro-businesses because this rule does not apply to single businesses.

Mr. Reisman has further determined that there are no economic costs to persons required to comply with the rule.

The Texas Ethics Commission invites comments on the proposed rule from any member of the public. A written statement should be mailed or delivered to David A. Reisman, Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, or by facsimile (FAX) to (512) 463-5777. A person who wants to offer spoken comments to the commission concerning the proposed rule may do so at any commission meeting during the agenda item "Communication to the Commission from the Public" and during the public comment period at a commission meeting when the commission considers final adoption of the proposed rule. Information concerning the date, time, and location of commission meetings is available by telephoning (512) 463-5800 or, toll free, (800) 325-8506.

The amendment to §6.5 is proposed under Government Code, Chapter 571, §571.062, which authorizes the commission to adopt rules concerning the laws administered and enforced by the commission.

The proposed amendment to §6.5 affects §571.062 of the Government Code.

§6.5. Authority To Adopt Rules.

(a) This title is adopted under the authority granted by the Act, the Administrative Procedure Act, and by any other law administered and enforced by the commission that establishes the commission's authority to adopt rules.

(b) The commission will not adopt a rule that in the opinion of the commission, directly addresses the subject matter of pending litigation known to the commission.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505401
David A. Reisman
Executive Director
Texas Ethics Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-5800

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CHAPTER 18. GENERAL RULES CONCERNING REPORTS

1 TAC §18.23

The Texas Ethics Commission proposes an amendment to §18.23, relating to administrative waivers of fines.

Section 18.23 amends the rule relating to administrative waivers of fines by extending the reasons for which the executive director may grant a waiver of a late fine assessed in connection with a personal financial statement. Currently, the executive director has the authority to administratively waive a late fine for certain filers if the personal financial statement was the first one that the filer was required to file. The proposed rule would allow the executive director to waive a late fine for certain filers if the personal financial statement was the first one to be filed late.

Section 18.23 also clarifies the applicability of the rule in connection with campaign finance reports.

David A. Reisman, Executive Director, has determined that for each year of the first five years the rule is in effect there will be no fiscal implication for the state and no fiscal implication for local

government as a result of enforcing or administering the rule as proposed. Mr. Reisman has also determined that this rule will have no local employment impact.

Mr. Reisman has also determined that for each year of the first five years the rule is in effect, the anticipated public benefit will be a more efficient method of considering waivers of late fines regarding certain personal financial statements.

Mr. Reisman has also determined there will be no direct adverse effect on small businesses or micro-businesses because this rule does not apply to single businesses.

Mr. Reisman has further determined that there are no economic costs to persons required to comply with the rule.

The Texas Ethics Commission invites comments on the proposed rule from any member of the public. A written statement should be mailed or delivered to David A. Reisman, Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, or by facsimile (FAX) to (512) 463-5777. A person who wants to offer spoken comments to the commission concerning the proposed rule may do so at any commission meeting during the agenda item "Communication to the Commission from the Public" and during the public comment period at a commission meeting when the commission considers final adoption of the proposed rule. Information concerning the date, time, and location of commission meetings is available by telephoning (512) 463-5800 or, toll free, (800) 325-8506.

The amendment to §18.23 is proposed under Government Code, Chapter 571, §571.062, which authorizes the commission to adopt rules concerning the laws administered and enforced by the commission.

The proposed amendment to §18.23 affects Chapter 572 of the Government Code.

§18.23. Administrative Waiver of Fine.

(a) A filer may request the executive director to waive a late fine by submitting an affidavit to the executive director that states facts that establish that:

(1) the report was filed late because of a medical emergency or condition that involved the filer, a family member or relative of the filer, a member of the filer's household, or a person whose usual job duties include preparation of the report;

(2) the filer of the personal financial disclosure report is not an elected official, a candidate for election, or a salaried public servant, and the late report:

(A) was the first personal financial disclosure report [~~required to be~~] filed late by the filer under Government Code chapter 572; and

(B) was filed no later than 30 days after the individual was notified that the report appeared to be late;

(3) the filer of the campaign finance report:

(A) - (C) (No change.)

(4) - (5) (No change.)

(b) If, in the executive director's discretion, the affidavit establishes grounds for a waiver under this section, the executive director shall waive the fine.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505402
David A. Reisman
Executive Director
Texas Ethics Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-5800

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CHAPTER 20. REPORTING POLITICAL CONTRIBUTIONS AND EXPENDITURES
SUBCHAPTER F. REPORTING REQUIREMENT FOR A GENERAL-PURPOSE COMMITTEE

1 TAC §§20.417, 20.431, 20.434, 20.441

The Texas Ethics Commission proposes amendments to §§20.417, 20.431, 20.441, and new §20.434, relating to alternative reporting requirements for general-purpose committees.

Section 20.417 relates to the filing requirement of a campaign treasurer of a general-purpose committee whose appointment was terminated. The amendment reflects the reporting requirement of new §20.434.

Section 20.431 relates to the filing requirement of a general-purpose committee that files campaign finance reports monthly. The amendment reflects the reporting requirement of new §20.434.

Section 20.441 relates to the contents of a dissolution report filed by a general-purpose committee. The amendment reflects the reporting requirement of new §20.434.

Section 20.434 clarifies §254.1541 of the Election Code by providing that the alternative reporting requirement applies only to political contributions.

David A. Reisman, Executive Director, has determined that for each year of the first five years the rules are in effect there will be no fiscal implication for the state and no fiscal implication for local government as a result of enforcing or administering the rules as proposed. Mr. Reisman has also determined that these rules will have no local employment impact.

Mr. Reisman has also determined that for each year of the first five years the rules are in effect, the anticipated public benefit will be clarification to §254.1541 of the Election Code.

Mr. Reisman has also determined there will be no direct adverse effect on small businesses or micro-businesses because these rules do not apply to single businesses.

Mr. Reisman has further determined that there are no economic costs to persons required to comply with these rules.

The Texas Ethics Commission invites comments on the proposed rules from any member of the public. A written statement should be mailed or delivered to David A. Reisman, Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, or by facsimile (FAX) to (512) 463-5777. A person who wants to offer spoken comments to the commission concerning the proposed rules may do so at any commission meeting during the agenda item "Communication to the Commission from the Public" and during the public comment period at a commission

meeting when the commission considers final adoption of the proposed rules. Information concerning the date, time, and location of commission meetings is available by telephoning (512) 463-5800 or, toll free, (800) 325-8506.

The amendments to §§20.417, 20.431, 20.441, and new §20.434 are proposed under Government Code, Chapter 571, §571.062, which authorizes the commission to adopt rules concerning the laws administered and enforced by the commission.

The proposed amendments to §§20.417, 20.431, 20.441, and new §20.434 affect §254.1541 of the Election Code.

§20.417. Termination Report.

(a) If the campaign treasurer appointment of a general-purpose committee is terminated, the campaign treasurer whose appointment was terminated shall file a termination report that contains the information listed in §20.433 of this title (relating to Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures), except as provided by §20.434 of this title (relating to Alternate Reporting Requirements for Certain General-Purpose Committees).

(b) - (e) (No change.)

§20.431. Monthly Reporting.

(a) A monthly report filed by a general-purpose committee shall include the information required by §20.433 of this title (relating to Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures), except that the threshold reporting amount of $50 set out in §20.433(11)-(16), and (20) of this title (relating to Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures) does not apply to a general-purpose committee reporting monthly. For a general-purpose committee reporting monthly, the threshold reporting amount under §20.433(11)-(16) and (20) of this title is $10, except as provided by §20.434 of this title (relating to Alternate Reporting Requirements for Certain General-Purpose Committees).

(b) - (d) (No change.)

§20.434. Alternate Reporting Requirements for General-Purpose Committees.

(a) This section and Election Code §254.1541 apply only to a general-purpose committee with less than $20,000 in one or more accounts maintained by the committee in which political contributions are deposited, as of the last day of the preceding reporting period for which the committee was required to file a report.

(b) The alternative reporting requirement in Election Code §254.1541 applies only to contributions.

(c) A report by a campaign treasurer of a general-purpose committee to which this section and Election Code §254.154 apply shall include the information required by §20.433 of this title (Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures), except that the campaign treasurer may choose a threshold reporting amount for political contributions of $100 instead of the threshold reporting amount of $50 set out in §§20.433(a)(11) and (a)(20)(B) of this title.

(d) A monthly report by a campaign treasurer of a general-purpose committee to which this section and Election Code §254.154 apply shall include the information required by §20.433 of this title (Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures), except that the campaign treasurer may choose a threshold reporting amount for political contributions of $20 instead of the threshold reporting amount of $10 set out in §§20.433(a)(11) and (a)(20)(B) of this title.

§20.441. Contents of Dissolution Report.

A dissolution report must contain:

(1) the information listed in §20.433 of this title (relating to Contents of General-Purpose Committee Sworn Report of Contributions and Expenditures), except as provided by §20.434 of this title (relating to Alternate Reporting Requirements for Certain General-Purpose Committees); and

(2) the following sworn statement, signed by the general-purpose committee's campaign treasurer, and properly notarized: "I, the undersigned campaign treasurer, do not expect the occurrence of any further reportable activity by this general-purpose committee for this or any other campaign or election for which reporting under the Election Code is required. I declare that all of the information required to be reported by me has been reported. I understand that designating a report as a dissolution report terminates the appointment of campaign treasurer. I further understand the circumstances in which the general-purpose committee may not make or authorize political expenditures or accept political contributions without having an appointment of campaign treasurer on file."

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505403
David A. Reisman
Executive Director
Texas Ethics Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-5800

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SUBCHAPTER I. RULES APPLICABLE TO A POLITICAL PARTY'S COUNTY EXECUTIVE COMMITTEE

1 TAC §20.553, §20.555

The Texas Ethics Commission proposes amendments to §20.553 and §20.555, relating to the filing requirements for a county executive committee.

Section 20.553 provides that county executive committees that make or accept political contributions that in the aggregate, exceed $5,000 in a calendar year, to appoint a campaign treasurer and file campaign finance reports. The proposed rule would track a statutory change and raise the threshold amount for required appointment of a campaign treasurer and filing of campaign finance reports. If the committee accepts or makes political contributions that in the aggregate do not exceed $25,000 in a calendar year, the committee is not required to file a campaign treasurer appointment.

Section 20.555, requires county executive committees to appoint a campaign treasurer and file campaign finance reports if the committee accepts or makes political contributions that in the aggregate exceed $5,000. The proposed rule would raise the threshold to $25,000, to reflect the new law.

David A. Reisman, Executive Director, has determined that for each year of the first five years the rules are in effect there will

be no fiscal implication for the state and no fiscal implication for local government as a result of enforcing or administering the rules as proposed. Mr. Reisman has also determined that these rules will have no local employment impact.

Mr. Reisman has also determined that for each year of the first five years the rules are in effect, the anticipated public benefit will be that the threshold referenced in the rules are consistent with the threshold set by the statute.

Mr. Reisman has also determined there will be no direct adverse effect on small businesses or micro-businesses because these rules do not apply to single businesses.

Mr. Reisman has further determined that there are no economic costs to persons required to comply with the rules.

The Texas Ethics Commission invites comments on the proposed rules from any member of the public. A written statement should be mailed or delivered to David A. Reisman, Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, or by facsimile (FAX) to (512) 463-5777. A person who wants to offer spoken comments to the commission concerning the proposed rules may do so at any commission meeting during the agenda item "Communication to the Commission from the Public" and during the public comment period at a commission meeting when the commission considers final adoption of the proposed rules. Information concerning the date, time, and location of commission meetings is available by telephoning (512) 463-5800 or, toll free, (800) 325-8506.

The amendments to §20.553 and §20.555 are proposed under Government Code, Chapter 571, §571.062, which authorizes the commission to adopt rules concerning the laws administered and enforced by the commission.

The proposed amendments to §20.553 and §20.555 affect §253.031 of the Election Code.

§20.553. County Executive Committee Accepting Contributions or Making Expenditures Totaling $25,000 [~~$5,000~~] or Less.

(a) A county executive committee accepting political contributions or making political expenditures totaling $25,000 [~~$5,000~~] or less in a calendar year is not required to:

(1) - (2) (No change.)

(b) A county executive committee described in subsection (a) of this section is required to comply with §20.551 of this title (relating to Obligation To Maintain Records).

§20.555. County Executive Committee Accepting Contributions or Making Expenditures That Exceed $25,000 [~~$5,000~~].

(a) A county executive committee described by subsection (b) of this section is subject to the requirements of Subchapter F of this chapter (relating to Reporting Requirements for a General-Purpose Committee), except where those rules conflict with this subchapter. In the case of conflict, this subchapter prevails over Subchapter F of this chapter.

(b) A county executive committee that accepts political contributions or that makes political expenditures that, in the aggregate, exceed $25,000 [~~$5,000~~] in a calendar year shall file:

(1) - (2) (No change.)

(c) Contributions accepted from corporations and labor organizations under §24.19 of this title (relating to Contributions to a Political Party) and reported under Subchapter H of this chapter (relating to Accepting and Reporting Contributions from Corporations and Labor Organizations) do not count against the $25,000 [~~$5,000~~] thresholds described in subsection (b) of this section.

(d) A county executive committee that filed a campaign treasurer appointment and reports of contributions and expenditures may file the report due by January 15 as its final report. Filing such a report will notify the filing authority that the county executive committee does not intend to file reports in the next calendar year unless it exceeds one of the $25,000 [~~$5,000~~] thresholds.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505412
David A. Reisman
Executive Director
Texas Ethics Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-5800

CHAPTER 22. RESTRICTIONS ON CONTRIBUTIONS AND EXPENDITURES

1 TAC §22.25

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Ethics Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Ethics Commission proposes the repeal of §22.25, relating to the maintenance of political contributions in bank accounts.

Section 22.25 requires both campaign and officeholder contributions to be commingled in each account kept by a candidate or officeholder. Commingling funds is no longer required. Section 253.040 of the Election Code, provides that "each candidate or officeholder shall keep the person's campaign and officeholder contributions in one or more accounts that are separate from any other account maintained by the person." House Bill 1606, 78th Legislature, Regular Session. The repeal of the rule would conform to §253.040 of the Election Code.

David A. Reisman, Executive Director, has determined that for each year of the first five years that the repeal of §22.25 is in effect there will be no fiscal implication for the state and no fiscal implication for local government as a result of enforcing or administering the repeal as proposed. Mr. Reisman has also determined that the repeal will have no local employment impact.

Mr. Reisman has also determined that for each year of the first five years the repeal of §22.25 is in effect, the anticipated public benefit will be clarity in what is required by the law.

Mr. Reisman has also determined there will be no direct adverse effect on small businesses or micro-businesses because this rule does not apply to single businesses.

Mr. Reisman has further determined that there are no economic costs to persons required to comply with the repeal of §22.25.

The Texas Ethics Commission invites comments on the proposed repeal of §22.25 from any member of the public. A written statement should be mailed or delivered to David A. Reisman, Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, or by facsimile (FAX) to (512) 463-5777. A person who wants to offer spoken comments to the commission concerning the proposed repeal may do so at any commission meeting during the agenda item "Communication to the Commission from the Public" and during the public comment period at a commission meeting when the commission considers final adoption of the proposed repeal. Information concerning the date, time, and location of commission meetings is available by telephoning (512) 463-5800 or, toll free, (800) 325-8506.

The repeal of §22.25 is proposed under Government Code, Chapter 571, §571.062, which authorizes the commission to adopt rules concerning the laws administered and enforced by the commission.

The proposed repeal of §22.25 affects §253.040 of the Election Code.

§22.25. Maintenance of Political Contributions in Bank Accounts.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505413
David A. Reisman
Executive Director
Texas Ethics Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-5800

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PART 5. TEXAS BUILDING AND PROCUREMENT COMMISSION

CHAPTER 111. EXECUTIVE ADMINISTRATION

SUBCHAPTER A. ADMINISTRATION

1 TAC §111.8

The Texas Building and Procurement Commission (TBPC) proposes new §111.8, concerning the establishment of an agency sick leave pool. The new rule is proposed pursuant to Texas Government Code §661.002. That statutory provision authorizes, and requires, a state agency to adopt rules to establish a voluntary sick leave pool program.

Stephen D. Thomas, Human Resources Director, has determined that for each year of the first five-year period the proposed rule is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the proposed rule.

Mr. Thomas has also determined that for each year of the first five-year period the proposed rule is in effect the public will benefit from the flexibility afforded to agency employees or their immediate family members suffering from a catastrophic illness or injury.

Mr. Thomas has also determined that there will be no effect on individuals or large, small, and micro-businesses as a result of the adoption of the proposed rule.

Mr. Thomas has also determined that for each year of the first five-year period the proposed rule is in effect there should be no effect on a local economy; therefore, no local employment impact statement is required under the Administrative Procedure Act, Texas Government Code §2001.022.

Interested persons may submit written comments (12 copies) on the proposed rule to Ingrid K. Hansen, General Counsel, Texas Building and Procurement Commission, P.O. Box 13047, Austin, Texas 78711-3047. Comments may be submitted electronically to *rulescomments@tbpc.state.tx.us*. For comments submitted electronically, please include "Proposed Sick Leave Pool Rule" in the subject line. The deadline for submission of comments is 30 days from the date of publication of the proposed rules in the *Texas Register*. Comments should be organized in a manner consistent with the organization of the proposed rule. For further information, please call: (512) 463-3960.

The new rule is proposed under Texas Government Code §661.002, which authorizes a state agency to establish a sick leave pool for its employees.

The statutory provisions affected by the proposed rule are those set forth in Chapters 661 and 2152 of the Texas Government Code.

§111.8. Sick Leave Pool.

A sick leave pool is established to alleviate hardship caused to an employee and employee's immediate family if a catastrophic illness or injury forces the employee to exhaust all sick leave time earned by that employee and to lose compensation from the state.

(1) The commission's Human Resources Director is designated as the pool administrator.

(2) The pool administrator will recommend a policy, operating procedures, and forms for the administration of this section to the Executive Director.

(3) Operation of the pool shall be consistent with Texas Government Code, Chapter 661.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505352
Ingrid K. Hansen
General Counsel
Texas Building and Procurement Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-7829

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TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 77. SERVICE CONTRACT PROVIDERS AND ADMINISTRATORS

16 TAC §§77.1, 77.10, 77.21, 77.22, 77.70, 77.72, 77.80, 77.90

The Texas Department of Licensing and Regulation ("Department") proposes amendments to existing rules at 16 Texas Administrative Code, §§77.1, 77.10, 77.21, 77.70, 77.80, and 77.90, and new rules §77.22 and §77.72, concerning service contract providers and administrators.

The amendments and new rules are necessary to implement acts of the 79th Texas Legislature, House Bill 1286. House Bill 1286 makes a number of amendments to Texas Occupations Code, Chapter 1304, including adding a registration requirement for administrators of service contracts and establishing minimum surplus and paid-in capital requirements for insurers issuing reimbursement insurance policies that are used as financial security by service contract providers. The bill takes effect January 1, 2006, except for certain provisions relating to the required registration of administrators, which take effect March 1, 2006. In addition, the amendments and new rules are necessary to make technical updates and corrections to the rules for the service contract program. References to statutes and rules are updated throughout the rules.

The title of the chapter is amended to include "Administrators." In §77.10 the definition of "consumer" is deleted as unnecessary because the same term is already defined somewhat differently in Texas Occupations Code, Chapter 1304. A definition of "third-party administration of a service contract" is added to clarify the statutory definition of "administrator" in Texas Occupations Code, §1304.002, by specifying the activities that constitute third party administration. The heading of §77.21 is amended to specify that the requirements of that section apply both to initial registration and renewal and apply specifically to providers. As a result of changes in statutory language, new language is added in subsection (b) of §77.21 to state explicitly that a registration is valid for one year and must be renewed annually. New language in proposed subsection (c) clarifies that initial and renewal applications for registration must be on a form prescribed by the executive director.

New §77.22 establishes registration and renewal requirements for administrators. Subsection (a) restates the requirement of House Bill 1286 that on or after March 1, 2006 administrators must be registered with the Department. Subsection (b) clarifies that the registration is valid for one year and must be renewed annually. Subsections (c), (d), and (e) establish administrator registration and renewal requirements that are similar to those for providers in §77.21.

Amendments to §77.70 make certain responsibilities that currently apply to providers also apply to administrators. An administrator that is appointed by a provider to perform certain activities will be responsible for providing those activities in accordance with statutory and rule requirements. However, even if the provider delegates certain activities to an administrator, the provider will remain responsible for seeing that those activities are performed in accordance with statutory and rule requirements.

New §77.72 implements new financial security requirements added by House Bill 1286. Subsection (a) makes clear that the issuance of a provider's registration or renewal, if the provider is using a reimbursement insurance policy to meet financial security requirements, is contingent upon the reimbursement insurer satisfying the requirements of Texas Occupations Code, §1304.152(a-1). That statutory provision establishes surplus and paid-in capital requirements for the insurer and requires the insurer to provide to the executive director audited financial statements, National Association of Insurance Commissioners annual statement, and actuarial certification if the certification is required and filed in the insurer's state of domicile. Subsection (b) requires that a reimbursement insurance policy must include the Department's prescribed "Service Contract Provider Texas Endorsement" or equivalent language. The Department's practice has been to request that reimbursement insurance policies include the endorsement, which contains statutorily-required provisions. The new rule would require use of the endorsement unless the policy contains equivalent language. The rule is needed to ensure that reimbursement insurance policies include provisions required by Texas Occupations Code, Chapter 1304.

Section 77.80 is amended to specify the provider fees for renewal and initial registration. The new subsections (d) and (e) establish an initial registration fee and annual renewal fee for an administrator and set both fees at $250. The fee for a duplicate or amended registration certificate is lowered to $25, consistent with similar fees in other Department programs.

Section 77.90 is amended to update statutory references, remove a reference to "the Act" which is not a defined term, make a technical correction to the language concerning imposing an administrative penalty, and add that the possible penalties for a violation include denial of a registration.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the new and amended rules are in effect there will be some additional costs to the Department in registering and regulating administrators. There will also be some additional costs to the Department due to increased review of provider qualifications in the application and renewal process. These additional costs are not expected to be significant and should be absorbed within existing Department resources. There will also be some additional revenue from the additional fees established in §77.80. The Department does not anticipate that the additional revenue will be significant, and the amount should be sufficient to offset additional costs to the state. The Department anticipates that the total number of registered administrators will be no more than 50. There will be no cost to local government as a result of enforcing or administering the new and amended rules.

Mr. Kuntz also has determined that for each year of the first five-year period the amendments and new rules are in effect, the public benefit will be added protection for service contract holders. The new requirements for service contract providers, particularly the financial security requirements, implemented by these rules should help to protect service contract holders against losses resulting from business failures of providers and insurers. Contract holders will also have a greater measure of protection because administrators, who may be processing and handling claims of contract holders, will now be subject to regulation.

Mr. Kuntz has determined that there will be some additional costs to persons who are required to comply with the proposed amendments and new rules, including small or micro-businesses. Administrators, which may be small or micro-businesses, will now be required to pay an initial registration fee of $250 and an annual renewal fee of $250. Providers and reimbursement insurers may incur some additional costs in complying with the new financial security requirements. The amount of any such costs is unknown.

Comments on the proposal may be submitted to Tamala Fletcher, Legal Assistant, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, facsimile (512) 475-3032, or electronically: tamala.fletcher@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register*.

The amendments and new rules are proposed under Texas Occupations Code, Chapter 1304 and Texas Occupations Code, Chapter 51, which authorize the Department to adopt rules as necessary to implement these chapters. In particular, the amendments and new rules implement acts of the 79th Texas Legislature, House Bill 1286.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapters 51 and 1304. No other statutes, articles, or codes are affected by the proposal.

§77.1. Authority.

These rules are promulgated under the authority of Texas Occupations Code, Chapter 1304 [~~Chapter 20, Title 132, Revised Civil Statutes, Article 9034~~] and Texas Occupations Code, Chapter 51.

§77.10. Definitions.

The following words and terms, as used in this Chapter and Texas Occupations Code, Chapter 1304, have the following meanings: [~~Consumer--A purchaser of a service contract sold in Texas.~~]

(1) "Third-party administration of a service contract" includes any of the following activities performed on behalf of a service contract provider:

(A) performing or arranging the collection, maintenance, or disbursement of money to compensate any party for claims or repairs pursuant to a service contract;

(B) participating in the processing or adjustment of claims arising under a service contract;

(C) maintaining records required by Texas Occupations Code, Chapter 1304; or

(D) complying with provider requirements, other than financial security requirements, of Texas Occupations Code, Chapter 1304.

(2) The term "third party administration of a service contract" does not include the performance of repairs, or clerical functions ancillary to the performance of repairs, by a repair facility that performs no other activities with respect to a service contract.

§77.21. Registration and Renewal Requirements-- Provider.

(a) No person may operate as a provider of service contracts, or offer to be a provider of service contracts in this state without first registering with the department unless the service contracts offered by such person are specifically exempt from the application of Texas Occupations Code, Chapter 1304 [~~Article 9034~~].

(b) A registration is valid for one year from the date issued and must be renewed annually.

(c) [~~(b)~~] Both initial and renewal applications for registration must provide the department [~~Department~~] with all information required, on a form prescribed by the executive director.

(d) [~~(c)~~] Both initial and [~~or~~] renewal applications must be accompanied by the required fee(s).

(e) [~~(d)~~] Falsification of information on an application is cause for denial and/or revocation of the registration.

§77.22. Registration and Renewal Requirements--Administrator.

(a) On or after March 1, 2006, no person may operate as an administrator for a provider or offer to act as an administrator for a provider operating in this state without first registering with the department.

(b) A registration is valid for one year from the date issued and must be renewed annually.

(c) Both initial and renewal applications for registration must provide the department with all information required, on a form prescribed by the executive director.

(d) Both initial and renewal applications must be accompanied by the required fee(s).

(e) Falsification of information on an application is cause for denial and/or revocation of the registration.

§77.70. Responsibilities of Registrant --Provider and Administrator [~~General~~].

(a) The provider and/or any administrator appointed by the provider are responsible for notifying [~~A registrant shall notify~~] service contract holders [~~recipients~~] of the name, mailing address, and telephone number of the department. The notification shall contain a statement that unresolved complaints concerning a registrant or questions concerning the regulation of service contract providers may be addressed to the department. The notification shall be included on all written service contacts. The notification may be stamped on the contract or printed on a separate sheet and stapled to the contract.

(b) A provider [~~All registrants~~] shall report to the department within 30 days, any change in information required by §77.21 [~~of this title (relating to Registration Requirements)~~].

(c) An administrator shall report to the department within 30 days, any change in information required by §77.22.

(d) [~~(c)~~] Upon notification by the department, a provider and/or administrator [~~the registrant~~] shall allow the department to audit records required to be maintained by Texas Occupations Code, Chapter 1304 [~~Article 9034 to be maintained~~].

(e) [~~(d)~~] The provider and/or any administrator appointed by the provider are responsible for providing [~~A service contract provider shall provide~~] a copy of the service contract to the service contract holder within 45 days from the date of purchase.

§77.72. Financial Security.

(a) The department may not issue a registration or renewal of a registration to a provider that uses a reimbursement insurance policy to comply with the financial security requirements of Texas Occupations Code, §1304.151, unless the insurer issuing the policy has provided all of the information and met all of the requirements set forth in Texas Occupations Code, §1304.152(a-1).

(b) A reimbursement insurance policy that is used to comply with the financial security requirements of Texas Occupations Code, §1304.151 must include the "Service Contract Provider Texas Endorsement" prescribed by the executive director, or equivalent language.

§77.80. Fees[~~--Registration~~].

(a) All registration fees are non-refundable.

(b) The initial [~~one year~~] registration fee [~~fees~~] for a service contract provider shall be $250.[~~:~~]

[~~(1) $250 for registrants providing 0 to 250 service contracts;~~]

[(2) $500 for registrants providing 251 to 499 service contracts; and]

[(3) $1,000 for registrants providing 500 or more service contracts.]

(c) The annual renewal fee for a service contract provider shall be:

(1) $250 for registrants providing 0 to 250 service contracts;

(2) $500 for registrants providing 251 to 499 service contracts; and

(3) $1,000 for registrants providing 500 or more service contracts.

(d) The initial registration fee for an administrator shall be $250.

(e) The annual renewal fee for an administrator shall be $250.

(f) [(c)] A $25 [$50] fee shall be charged for duplicate or amended registration certificates.

(g) [(d)] Late renewal fees for registrations issued under this chapter are provided under §60.83 of this title (relating to Late Renewal Fees).

§77.90. Sanctions--Administrative Sanctions/Penalties.

If a person violates Texas Occupations Code, Chapter 1304 [Chapter 20, Title 132, Revised Civil Statutes, Article 9034 (1999),] or a rule, or order of the executive director [Executive Director] or commission [Commission relating to the Act], proceedings may be instituted to impose administrative sanctions and/or [recommend] administrative penalties or to deny a registration in accordance with [Article 9034 or the] Texas Occupations Code, Chapters [Chapter] 51 and 1304 and 16 Texas Administrative Code, Chapter 60 [(1999) of this Title] (relating to the Texas Department of Licensing and Regulation).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505400
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-6208

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TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 4. RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER C. TEXAS SUCCESS INITIATIVE

19 TAC §4.59

The Texas Higher Education Coordinating Board proposes amendments to §4.59, concerning the determination of readiness to perform freshman-level academic coursework.

Specifically, this amendment deletes the requirement that students must retake an assessment instrument in order for an institution to determine if the student is ready to perform freshman-level coursework.

Dr. Glenda Barron, Associate Commissioner, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rule.

Dr. Barron has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be the increased flexibility and responsibility granted to institutions of higher education to better serve their underprepared students by determining readiness to perform freshman-level academic coursework on an individual basis according to the needs of the student. There is no effect on small businesses. There is no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Cynthia Ferrell, P.O. Box 12788, Austin, Texas 78711, cynthia.ferrell@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendment is proposed under the Texas Education Code, §51.307, which provides the Coordinating Board with the authority to adopt rules for the administration of Texas Education Code §51.3062.

The amendment affects Texas Education Code §51.3062.

§4.59. Determination of Readiness to Perform Freshman-level Academic Coursework.

(a) (No change.)

(b) As indicators of readiness, institutions shall consider, as appropriate:

(1) - (3) (No change.)

(4) Performance on an assessment retake for those students who perform at or below the following scores:

(A) ASSET: Reading Skills - 35; Elementary Algebra - 30; and Writing Skills (objective) - 35.

(B) COMPASS: Reading Skills - 64; Algebra - 23; Writing Skills (objective) - 44.

(C) ACCUPLACER: Reading Comprehension - 61; Elementary Algebra - 42; Sentence Skills - 62.

(D) THEA: Reading - 201; Mathematics - 206; Writing - 205.

(E) An essay with a score of 5 will meet these criteria if the student meets the objective writing test standard.

(5) [(4)] Other indicators of readiness, as determined by the institution.

[(c) The determination shall include the requirement that a student shall retake an assessment instrument described in §4.56 of this title (relating to Assessment Instruments) if the student did not initially perform at or above the following scores:]

[(1) ASSET: Reading Skills - 35; Elementary Algebra - 30; and Writing Skills (objective) - 35.]

[(2) COMPASS: Reading Skills - 64; Algebra - 23; Writing Skills (objective) - 44.]

[(3) ACCUPLACER: Reading Comprehension - 61; Elementary Algebra - 42; Sentence Skills - 62.]

[(4) THEA: Reading - 201; Mathematics - 206; Writing - 205.]

[(5) An essay with a score of 5 will meet these criteria if the student meets the objective writing test standard.]

(c) [(d)] A student may retake an assessment instrument at any time, subject to availability, to determine the student's readiness to perform freshman-level academic coursework.

(d) [(e)] An institution shall, as soon as practicable and feasible, indicate a student's readiness in reading, mathematics, and writing on the transcript of each student.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505385
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: January 26, 2006
For further information, please call: (512) 427-6114

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CHAPTER 7. PRIVATE AND OUT-OF-STATE PUBLIC POSTSECONDARY EDUCATIONAL INSTITUTIONS OPERATING IN TEXAS

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §7.3

The Texas Higher Education Coordinating Board proposes amendments to §7.3, concerning definitions.

Specifically, the amendment to §7.3 adds new definitions pertaining to "fictitious degree," "fraudulent or substandard degree," and "protected term." These amendments are submitted in order to implement the requirements of House Bill 1173, 79th Texas Legislature, Regular Session. House Bill 1173 amends the Texas Education Code (Chapter 61, Subchapter G) to prohibit the use of fraudulent or substandard degrees and directs the Coordinating Board to provide consumer information about such degrees and provide a mechanism for institutions to establish their legitimacy for use of their degrees in Texas.

Dr. Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, has determined that for each year of the first five years the section is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rule.

Dr. Raney has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be the increased protection of the public from individuals using fraudulent or substandard degrees to secure employment or promotions and increased compensation. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or carol.raney@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendment is proposed under the Texas Education Code, §§61.301 - 61.319, concerning regulation of private postsecondary education institutions.

The amendment affects Texas Education Code, §§61.301 - 61.319.

§7.3. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (8) (No change.)

(9) Exempt institution--An institution that is accredited by an agency recognized by the Board under §7.2(a) of this title (relating to Authority) or an entity described in the Texas Education Code, §61.003(8).

(10) Fictitious degree--A counterfeit or forged degree or a degree that has been revoked.

(11) Fraudulent or substandard degree--A degree conferred by a person who, at the time the degree was conferred, was:

(A) operating in this state in violation of this subchapter;

(B) not eligible to receive a certificate of authority under this subchapter and was operating in another state in violation of a law regulating the conferral of degrees in that state or in the state in which the degree recipient was residing or without accreditation by a recognized accrediting agency, if the degree is not approved through the review process described by §7.12 of this title (relating to Review and Use of Degrees from Institutions Not Eligible for Certificates of Authority); or

(C) not eligible to receive a certificate of authority under this subchapter and was operating outside the United States, and whose degree the Board, through the review process described by §7.12 of this title, determines is not the equivalent of an accredited or authorized degree.

(12) [(9)] Home campus--The headquarters of an institution, such location to be determined as a matter of fact by the Commissioner based upon consideration of information such as, but not limited to the following:

(A) where the institution is chartered;

(B) the site, campus or city where the principal or chief executive's offices are located;

(C) the site, campus or city where the institution conducts the preponderance of its instructional activities; and

(D) any other pertinent and material facts.

(13) [~~(10)~~] Occasional courses--Courses offered not more than twice at any given location in the state.

(14) [~~(11)~~] Out-of-state public institution of higher education--Any senior college, university, technical institute, junior or community college, or the equivalent which is controlled by a public body organized outside the boundaries of the State of Texas.

(15) [~~(12)~~] Person--Any individual, firm, partnership, association, corporation, enterprise, or other private entity or any combination thereof.

(16) [~~(13)~~] Private postsecondary educational institution or institution--An educational institution which:

(A) is not a public junior college, public senior college or university, medical or dental unit or other agency as defined in Texas Education Code §61.003;

(B) is incorporated under the laws of this state, or maintains a place of business in this state, or has an agent or representative present in this state, or solicits business in this state; and

(C) furnishes or offers to furnish courses of instruction in person, by electronic media, or by correspondence leading to a degree; provides or offers to provide credits alleged to be applicable to a degree; or represents that credits earned or granted are collegiate in nature, including describing them as "college-level," or at the level of any protected academic term.

(17) [~~(14)~~] Program or Program of study--Any course or grouping of courses which are represented as entitling a student to a degree or to credits applicable to a degree.

(18) Protected term--the term "college," "university," "seminary," "school of medicine," "medical school," "health science center," "school of law," "law school," or "law center," its abbreviation, foreign cognate, or equivalents.

(19) [~~(15)~~] Recognized accrediting agency--Any accrediting agency the standards of accreditation or membership for which have been found by the Board to be sufficiently comprehensive and rigorous to qualify its institutional members for an exemption from the operation of this chapter.

(20) [~~(16)~~] Representative--A person who acts on behalf of an institution regulated under this subchapter. The term includes, without limitation, recruiters, agents, tutors, counselors, business agents, instructors, and any other instructional or support personnel.

(21) [~~(17)~~] The subchapter--Texas Education Code, Title 3, Chapter 61, Subchapter G, as amended, having an effective date of June 21, 1975.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505386
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: January 26, 2006
For further information, please call: (512) 427-6114

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19 TAC §§7.12 - 7.17

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Higher Education Coordinating Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Higher Education Coordinating Board proposes the repeal of §§7.12 - 7.17, concerning general provisions.

Specifically, this repeal clarifies language about prohibited acts, and adds the use of fraudulent or substandard degrees as a prohibited act. This repeal is submitted in order to implement the requirements of House Bill 1173, 79th Texas Legislature, Regular Session. House Bill 1173 amends the Texas Education Code (Chapter 61, Subchapter G) to prohibit the use of fraudulent or substandard degrees and directs the Coordinating Board to provide consumer information about such degrees and provide a mechanism for institutions to establish their legitimacy for use of their degrees in Texas.

Dr. Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, has determined that for each year of the first five years the repeal is in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the repeal.

Dr. Raney has also determined that for each year of the first five years the repeal is in effect, the public benefit anticipated as a result of administering the repeal will be the increased protection of the public from individuals using fraudulent or substandard degrees to secure employment or promotions and increased compensation. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the repeal as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or carol.raney@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The repeal is proposed under the Texas Education Code, §61.027, which provides the Board with general rule-making authority; Texas Education Code, §61.002, which establishes the Board as an agency charged to provide leadership and coordination for the Texas higher education system; Texas Education Code, §§61.301 - 61.319, concerning regulation of private postsecondary education institutions; §61.311, which provides the Board with the authority to promulgate rules governing certificates of authority; Texas Education Code, §§61.401 - 61.405, regarding regulation of public institutions of higher education established outside the boundaries of the State of Texas; and Texas Education Code, §61.403 which provides the Board with the authority to promulgate rules regarding out of state public institutions.

The repeal affects Texas Education Code, §§61.301 - 61.319, and Texas Education Code, §§61.401 - 61.405.

§7.12. Prohibitions Applicable to Nonexempt Institutions.

§7.13. Duties upon Dissolution of an Institution.

§7.14. Procedures Related to the Assessment of Administrative Penalties.

§7.15. Administrative Penalties.

§7.16. Injunctions.

§7.17. Civil Penalties.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

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Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: January 26, 2006
For further information, please call: (512) 427-6114

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19 TAC §§7.12 - 7.20

The Texas Higher Education Coordinating Board proposes new §§7.12 - 7.20, concerning prohibiting the use in Texas of fraudulent or substandard degrees.

Specifically, new §7.12 establishes procedures for reviewing degree from institutions not eligible for a certificate of authority to determine if they may be legally used in Texas. Changes to the existing §7.12, renumbered as §7.14, clarifies language about prohibited acts, and adds the use of fraudulent or substandard degrees as a prohibited act. A new §7.13 establishes the procedures for disseminating consumer protection information related to fraudulent or substandard degrees. A new §7.20 clarifies that violation of the subchapter is a violation of the Deceptive Trade Practices Act. The existing §§7.13 - 7.17 are renumbered as §§7.15 - 7.19, respectively, but are otherwise unchanged. These new sections are submitted in order to implement the requirements of House Bill 1173, 79th Texas Legislature, Regular Session. House Bill 1173 amends the Texas Education Code (Chapter 61, Subchapter G) to prohibit the use of fraudulent or substandard degrees and directs the Coordinating Board to provide consumer information about such degrees and provide a mechanism for institutions to establish their legitimacy for use of their degrees in Texas.

Dr. Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, has determined that for each year of the first five years the sections are in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Dr. Raney has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of administering the sections will be the increased protection of the public from individuals using fraudulent or substandard degrees to secure employment or promotions and increased compensation. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Carol Raney, Acting Assistant Commissioner for Academic Affairs and Research, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711 or carol.raney@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The new sections are proposed under the Texas Education Code, §§61.301 - 61.319, concerning regulation of private postsecondary education institutions.

The new sections affect Texas Education Code, §§61.301 - 61.319.

§7.12. Review and Use of Degrees from Institutions Not Eligible for Certificates of Authority.

(a) A person holding a degree from an institution that is not eligible to receive a certificate of authority may request a letter from the Board confirming that the institution is not eligible for a certificate of authority and providing the procedures for review and approval of the degree for use in Texas. The Board shall send a copy of the letter to the institution.

(b) Procedures for review and approval.

(1) An institution that confers a degree described in §7.3(11)(B) or (C) of this title (relating to Definitions), may request that the Board review and approve for use in Texas that degree, as provided in those sections. The person or institution shall submit the request on a form created by the Board.

(2) The Commissioner shall apply the standards provided in §7.7 of this title (relating to Standards for Certificates of Authority) to determine if the degrees awarded by a person or institution are equivalent to degrees granted by a private postsecondary educational institution or other person holding a certificate of authority from the Board.

(3) The Commissioner, or the Commissioner's designated representatives, and an ad hoc team of independent consultants, if the Commissioner finds that such a team would provide a benefit to the Board or to the institution, shall visit the institution and conduct an on-site survey to evaluate the application for review and approval. The visiting team shall be composed of people who have experience on the faculties or staffs of accredited institutions and who possess knowledge of accreditation standards.

(4) The Board shall charge the person or institution petitioning for review and approval a fee equal to the application fee for a certificate of authority or the actual cost of conducting the review, including travel expenses and cost of consultant fees, whichever is greater.

§7.13. Information Provided to Protect Public from Fraudulent, Substandard, or Fictitious Degrees.

(a) The Board shall disseminate the following information through the Board's Internet website:

(1) the accreditation status or the status regarding authorization or approval under this subchapter, to the extent known by the Board, of each exempt institution operating in the state, each postsecondary educational institution or other person that is regulated under §§7.1 - 7.10 of this title or for which a determination is made under §7.10(d) of this title (relating to Occasional Courses, Changes of Level at Exempt Institutions, and Out-of-State Public Institutions), and any institution offering fraudulent or substandard degrees, including:

(A) the name of each educational institution accredited, authorized, or approved to offer or grant degrees in this state;

(B) the name of each educational institution whose degrees the Board has determined may not be legally used in this state; and

(C) the name of each educational institution that the Board has determined to be operating in this state in violation of this subchapter; and

(2) any other information considered by the Commissioner to be useful to protect the public from fraudulent, substandard, or fictitious degrees.

(b) the Board shall utilize such usual and customary sources for determining the accreditation status of institutions; guides to international education; the Board's knowledge of legal actions taken against institutions, either by an agency of the state of Texas or agencies of other states or nations; or civil actions against institutions brought by governmental agencies or individuals.

(c) in determining the legitimacy of institutions headquartered or operating outside of Texas, the Board may determine if the state or nation in which the person or institution is headquartered, operates, or holds legal authorization to operate has standards and practices that are as rigorous as those of the Board's. A determination that a particular state or nation's standards or practices are not appropriately rigorous shall be sufficient reason to disapprove the use of the degrees of a person or institution.

§7.14. Prohibitions.

(a) A person or institution may not:

(1) Grant, award, or offer to award a degree on behalf of a nonexempt institution unless the institution has been issued a certificate of authority to grant the degree by the Board;

(2) Represent that credits earned or granted by that person or institution are applicable for credit toward a degree to be granted by some other person or institution except under conditions and in a manner specified under §7.6 of this title (relating to Certificate of Authority), and approved by the Board, or represent that credits earned or granted are collegiate in nature, including describing them as "college-level," or at the level of any protected academic term;

(3) Award or offer to award an honorary degree on behalf of a private postsecondary educational institution subject to the provisions of the subchapter, unless the institution has been awarded a certificate of authority to award such a degree, or solicits another person to seek or accept an honorary degree and, further, unless the degree shall plainly state on its face that it is honorary;

(4) Use a protected term in the official name or title of a nonexempt private postsecondary educational institution or describe an institution using any of these terms or a term having a similar meaning, except as authorized by the Board, or solicit another person to seek a degree or to earn a credit that is offered by an institution or establishment that is using a term in violation of this section;

(5) Use a protected term in the official name or title of an educational or training establishment or describe an institution using any of these terms or a term having a similar meaning, or solicit another person to seek a degree or to earn a credit that is offered by an institution or establishment that is using a term in violation of this section;

(6) Act as an agent who solicits students for enrollment in a private postsecondary educational institution subject to the provisions of the subchapter without a certificate of registration.

(7) Use or claim to hold a degree that the person knows is a fraudulent or substandard degree or is a fictitious degree:

(A) in a written or oral advertisement or other promotion of a business; or

(B) with the intent to:

(i) obtain employment;

(ii) obtain a license or certificate to practice a trade, profession, or occupation;

(iii) obtain a promotion, a compensation or other benefit, or an increase in compensation or other benefit, in employment or in the practice of a trade, profession, or occupation;

(iv) obtain admission to an educational program in this state; or

(v) gain a position in government with authority over another person, regardless of whether the actor receives compensation for the position.

(b) Institutions Located on Federal Land in Texas. An institution that is operating on land in Texas over which the federal government has exclusive jurisdiction shall limit the recruitment of students and advertising of the institution or its programs or courses to the confines of the federal land and to the military or civilian employees and their dependents who work or live on that land. The institution shall not enlist any agent, representative, or institution to recruit or to advertise by any medium, the institution or its programs or courses except on the federal land.

(c) A violation of this subsection may constitute a violation of the Texas Penal Code, §32.52. An offense under subsection (a)(1) - (6) of this section may be a Class A misdemeanor and an offense under subsection (a)(7) of this section may be a Class B misdemeanor.

§7.15. Duties upon Dissolution of an Institution.

(a) In the event any institution now or hereafter operating in this state proposes to discontinue its operation, the chief administrative officer, by whatever title designated, of said institution shall cause to be filed with the Board the original or legible true copies of all such academic records of said institution as may be specified by the Commissioner. Such records shall include, without limitation:

(1) such academic information as is customarily required by colleges when considering students for transfer or advanced study; and

(2) the academic records of each former student.

(b) In the event it appears to the Commissioner that any records of an institution that is discontinuing its operations are in danger of being destroyed, secreted, mislaid, or otherwise made unavailable to the Board, the Commissioner may seek, on the Board's behalf, court authority to take possession of such records.

(c) The Board shall maintain or cause to be maintained a permanent file of such records coming into its possession.

§7.16. Procedures Related to the Assessment of Administrative Penalties.

(a) If a person or institution violates a provision of this subchapter, the Commissioner may assess an administrative penalty against the person or institution as provided in this section.

(b) The Commissioner shall send written notice by certified mail to the person or institution charged with the violation. The notice shall state the facts on which the penalty is based, the amount of the penalty assessed, and the right of the person or institution to request a hearing.

(c) The Commissioner's assessment shall become final and binding unless, within 45 days of receipt of the notice of assessment, the person or institution invokes the administrative remedies contained in Chapter 1, Subchapter B of this title (relating to Hearings and Appeals).

(d) If the person or institution does not pay the amount of the penalty within 30 days of the date on which the assessment becomes final, the Commissioner may refer the matter to the attorney general for collection of the penalty, plus court costs and attorney fees.

§7.17. Administrative Penalties.

(a) Any person or institution that is neither exempt nor the holder of a certificate of authority to grant degrees, shall be assessed an administrative penalty of not less than $1,000 or more than $5,000 for, either individually or through an agent or representative:

(1) conferring or offering to confer a degree;

(2) awarding or offering to award credits purported to be applicable toward a degree to be awarded by another person or institution (except under conditions and in a manner specified and approved by the Board);

(3) representing that any credits offered are collegiate in nature subject to the provisions of this subchapter;

(4) Each degree conferred without authority, and each person enrolled in a course or courses at the institution whose decision to enroll was influenced by the misrepresentations, constitutes a separate offense.

(b) Any person or institution that violates §7.14(a)(4) or (5) of this title (relating to Prohibitions) shall be assessed an administrative penalty of not less than $1,000 or more than $3,000.

(c) Any agent who solicits students for enrollment in an institution subject to the provisions of the subchapter without a certificate of registration shall be assessed an administrative penalty of not less than $500 or more than $1,000. Each student solicited without authority constitutes a separate offense.

(d) Any operations which are found to be in violation of the law shall be terminated.

§7.18. Injunctions.

(a) The Commissioner may report possible violations of this subchapter to the attorney general. The attorney general, after investigation and consultation with the Board, shall bring suit to enjoin further violations.

(b) An action for an injunction under this section shall be brought in a district court in Travis County.

§7.19. Civil Penalties.

(a) A person who violates this subchapter or a rule adopted under this subchapter is liable for a civil penalty in addition to any injunctive relief or any other remedy allowed by law. A civil penalty may not exceed $1,000 a day for each violation.

(b) The attorney general, at the request of the Board, shall bring a civil action to collect a civil penalty under this section.

§7.20. Deceptive Trade Practices Act.

(a) A person who violates this subchapter commits a false, misleading, or deceptive act or practice within the meaning of the Texas Business & Commerce Code, §17.46.

(b) A public or private right or remedy under the Texas Business & Commerce Code, §17, may be used to enforce this section.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Jan Greenberg
General Counsel
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CHAPTER 13. FINANCIAL PLANNING
SUBCHAPTER H. REPORTING OF TUITION AND FEES

19 TAC §13.140 - 13.143

The Texas Higher Education Coordinating Board proposes new §§13.140 - 13.143, concerning Reporting of Tuition and Fees.

Senate Bill 1528, 79th Texas Legislature, Regular Session, enacted 2005 Tex.Sess.Law Serv. 288 (Vernon), requiring the Board to compile data on the tuition and fees charged by institutions and to report that data to the Legislature. This same legislation created Texas Education Code, §54.0015, authorizing the Board to adopt definitions of tuition and fees as necessary to ensure consistency. Specifically, proposed new §13.140 and §13.141 provide the purpose of and authority for these rules. Section 13.142 proposes fifteen definitions for the different types of tuition and fees charged by institutions. The procedures for reporting the types and amounts of tuition and fees to the Board are set out in proposed new §13.143.

Susan Brown has determined that for each year of the first five years the new sections are in effect, there will not be any fiscal implications to state or local government as a result of enforcing or administering the rules.

Ms. Brown has also determined that for each year of the first five years the new sections are in effect, the public benefit anticipated as a result of administering the sections will be the consistent use of terms by students, parents, legislature, and other interested parties regarding higher education tuition and fees. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Susan E. Brown, Assistant Commissioner, Planning and Accountability, P.O. Box 12788, Austin, Texas 78711; susan.brown@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The new sections are proposed under the Texas Education Code, §54.0015, and 2005 Tex.Sess.Law Serv. 288 (Vernon).

The new sections affect 2005 Tex.Sess.Law Serv. 288 (Vernon).

§13.140. Purpose.

The purpose of this subchapter is to establish the reporting requirements for institutions to submit data on tuition and fees and to provide uniform definitions for the different types of tuition and fees.

§13.141. Authority.

2005 Tex.Sess.Law Serv, 288 (Vernon) requires the Board to compile data on the tuition and fees charged at each two-year and four-year institution of public higher education and report that data to the Texas Legislature. Texas Education Code, §54.053 authorizes the Board to adopt rules to carry out the purposes of Texas Education Code, Chapter 54, Subchapter B.

§13.142. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Auxiliary fee--A mandatory or discretionary fee that an institution charges to recover costs from a student for a service or activity that is self-supporting.

(2) Coordinating Board--The Texas Higher Education Coordinating Board.

(3) Course fee--A mandatory fee required of all students enrolled in a given course; or a discretionary fee required of students in a given course who wish to participate in a special activity.

(4) Discretionary fee--An optional fee that the governing board of an institution is permitted, but not required, by statute to charge all students. Examples of this fee are parking fees charged under Texas Education Code, §54.505 and incidental fees charged under Texas Education Code, §54.504 and §130.084.

(A) Voluntary fee--A discretionary fee authorized under Texas Education Code, §§54.503, 54.5061 and 54.513, that is charged only to those students who make use of the service or item for which the fee is established.

(B) Matriculation fee--A discretionary fee authorized under Texas Education Code, §54.006(a), that an institution, other than a public community college or public technical college, may charge a student withdrawing from the institution before the first day of class.

(5) General academic teaching institution--An institution included in the provisions of Texas Education Code, §61.003(3).

(6) Incidental fee--A mandatory fee authorized by the governing board of an institution and collected under Texas Education Code, §55.16 or §130.084, and levied at the discretion of the governing board of an institution that is charged to all students; or a discretionary fee collected under Texas Education Code, §54.504 or §130.084, for particular services provided to students.

(7) Institution or institution of higher education--Any public technical institute, public junior college, public senior college or university, medical or dental unit, public state college, or other agency of higher education as defined in Texas Education Code, §61.003(8).

(8) Authorized by this chapter that an institution may charge only to a student, other than a student who is exempt from the fee, who uses the service or item for which the fee is established Mandatory fee--A fee authorized by statute or the governing board of an institution that is charged to a student upon enrollment. For institutions other than public community colleges, such fees would be required to be paid by the census date or other date as mandated by the state for formula funding purposes. Examples of such fees are: laboratory fees, course and incidental fees collected under Texas Education Code, §55.16(c), and other mandatory fees as authorized by the governing board of the institution. For public community colleges, such fees would include fees collected from a student under Texas Education Code, §130.084.

(A) Laboratory fee--A mandatory fee that is charged under Texas Education Code, §54.501.

(B) Compulsory fee--A mandatory fee authorized under Texas Education Code, §§54.503, 54.5061, and 54.513.

(9) Medical and dental unit--An institution included in the provisions of Texas Education Code, §61.003(5).

(10) Optional fee--Has the same meaning as discretionary fee defined in paragraph (4) of this section.

(11) Public junior or community college--Any junior or community college certified by the board in accordance with Texas Education Code, §61.063.

(12) Public technical institute--An institution included in the provisions of Texas Education Code, §61.003(7).

(13) Required fee--Has the same meaning as mandatory fee defined in paragraph (8) of this section.

(14) Tuition--Statutory, designated, and/or board-authorized tuition.

(A) Statutory tuition--A tuition charge authorized under Texas Education Code, §54.051, in an amount determined by the Texas Legislature for resident or nonresident students.

(B) Designated tuition--A tuition charge authorized under Texas Education Code, §54.0513, that an institution may impose on any graduate or undergraduate, resident or nonresident student, in an amount that the governing board of the institution considers necessary for the effective operation of the institution.

(C) Board authorized tuition--A tuition charge that a general academic teaching institution or a medical and dental unit may impose on any graduate resident or nonresident student in an amount as specified in Texas Education Code, §54.008.

(15) Tuition fee--Statutory, designated, and/or board-authorized tuition.

§13.143. Reporting

(a) By May 1, 2006, each institution shall report to the Board the types and amounts of tuition and fees charged to students by semester, beginning with the 2003 fall semester and including the 2005 spring semester.

(b) Beginning December 1, 2006, each institution shall report the types and amounts of tuition and fees charged to students by semester during the previous academic year.

(c) In reporting the types and amounts of tuition and fees charged to students, all institutions shall classify the tuition and fees according to the definitions of those terms provided in §13.142 of this title (relating to Definitions).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 21. STUDENT SERVICES
SUBCHAPTER E. TEXAS B-ON-TIME LOAN PROGRAM

19 TAC §21.127

The Texas Higher Education Coordinating Board proposes an amendment to §21.127, concerning the Texas B-On-Time Loan Program.

Specifically, the amendment requires each institution to adopt its own hardship policy and make it available for public review.

Lois Hollis, Assistant Commissioner for Student Services, has determined that for each year of the first five years the amendment is in effect, there will be no fiscal implications to state or local government as a result of enforcing or administering the rules.

Ms. Hollis has also determined that for each year of the first five years the amendment is in effect the public benefit anticipated as a result of administering the section will be that individuals will be better informed about their options to continue in the program when they experience hardships. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Lois Hollis, P.O. Box 12788, Austin, Texas 78711, (512) 427-6465, Lois.Hollis@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendment is proposed under the Texas Education Code, §56.453, which provides the Coordinating Board with the authority to adopt rules for the administration of Texas Education Code, §§56.451 - 56.465.

The amendment affects Texas Education Code, §§56.451 - 56.465.

§21.127. Hardship Provisions.

(a) - (b) (No change.)

(c) Each institution shall adopt a hardship policy under this section and have the policy available in writing in the financial aid office for public review upon request.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER NN. EXEMPTION PROGRAM FOR VETERANS AND THEIR DEPENDENTS (THE HAZLEWOOD ACT)

19 TAC §§21.2100 - 21.2107

The Texas Higher Education Coordinating Board proposes amendments to §§21.2100 - 21.2107, concerning the Exemption Program for Veterans and their Dependents (The Hazlewood Act).

Senate Bill 101 and Senate Bill 1528, 79th Legislature, Regular Session, amended Texas Education Code, §54.203, and added new §61.0516, changing eligibility requirements and procedures for the Exemption Program for Veterans and their Dependents. Rules were adopted on an emergency basis in July 2005. In August 2005, Attorney General Opinion GA 0347 was issued, regarding student eligibility requirements. In addition, Board staff met with college and Texas Veterans' Commission representatives several times since the adoption of rules in July to more fully clarify and develop program requirements and procedures. The proposed amendments are a result of the meetings and the new Attorney General's opinion. Specifically, changes to §21.2100 reflect the addition of definitions for terms that are used in the subchapter. They also include the elimination of definitions for mandatory fees, discretionary fees, and optional fees. The Board is currently developing formal definitions for these terms and new definitions will be added to rules in the future when they have been finalized. Changes to §21.2101(a) indicate in generic terms the fees that are to be exempted for individuals eligible for the Hazlewood exemption. The change to §21.2101(g) and (h) reflects new provisions included in Senate Bill 1528 regarding the value of exemptions to students taking extraordinarily expensive courses such as flight training. Changes to §21.2102 indicate, in keeping with the Opinion of the Office of the Attorney General (GA 0347), that veterans can meet the program residency requirement for time of entry if they were citizens of the United States at the time they entered the service and entered the service in Texas. Other changes are proposed to clarify program requirements and include veteran education benefits issued under Title 10, United States Code, Chapter 1607. Changes to §21.2103 are proposed to make the language flow more smoothly and indicate that the parent who was a member of the U.S. Armed Forces must have been a U.S. citizen and resident of Texas at the time of entry in order for the child to qualify for an exemption. Changes to §21.2104 reflect the fact that some institutions operate on a semester basis; some use the word "terms" to refer to their periods of study. The change to §21.2104(c) clarifies that although students are entitled to the exemption if they provide all the necessary information by the census date as indicated in subsection (b), an institution may grant the exemption if the student has submitted the application by the census date but does not have all the supporting materials in by that date as long as the remaining materials are received by the end of the term. Institutions are not required to allow students this additional time, but may do so. Changes to §21.2105(a) reflect new information that although most veterans lose eligibility for federal benefits after 10 years, some benefits extend beyond that period of time and that the DD214 does not currently provide enough information to determine a veteran's residency at the time he or she entered the service. Changes to §21.2105(b) clarify the documentation needed to determine whether the child of a deceased member of the Texas National Guard can qualify for an exemption. Changes to §21.2106 give institutions the option to allow individuals who claim eligibility to use the exemption if they have not provided all the documents as of the census date as long as the information is received by the school by the end of the term or semester. The change to §21.2107 clarifies that the student's consent would allow his or her current institution to receive information from the Hazlewood database, as well as previous schools that he or she might have attended.

Lois Hollis, Assistant Commissioner for Student Services, has determined that for each year of the first five years the amendments are in effect, there will be no fiscal implications to state

or local government as a result of enforcing or administering the rules.

Ms. Hollis has also determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of administering the sections will be that veterans and children using the exemption will know what is required for the exemption, and institutions will be more consistent in the information that they collect from students to determine eligibility. There is no effect on small businesses. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Lois Hollis, P.O. Box 12788, Austin, Texas 78711, (512) 427-6465, Lois.Hollis@thecb.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendments are proposed under the Texas Education Code, §54.203(i), which states that the Coordinating Board may adopt rules necessary to implement the program.

The amendments affect the Texas Education Code, §54.203.

§21.2100. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Attempted credit hours--Hours for which the veteran is registered as of the census date of a term or semester.

(2) [~~(1)~~] Board--The Texas Higher Education Coordinating Board.

(3) Census date--the date in an academic term or semester for which an institution is required to certify a person's enrollment in the institution to the board for the purposes of determining formula funding for the institution.

(4) [~~(2)~~] Children--Persons who were dependents of members of the armed forces of the United States [~~the veteran~~] at the time they were [~~he or she was~~] killed or died as a result of injuries directly associated with military service or dependents of members of the Texas National Guard and the Texas Air National Guard killed since January 1, 1946, while on active duty either in the service of Texas or the United States.

(5) [~~(3)~~] Citizen of Texas--A resident of Texas as determined in accordance with Chapter 21, §§21.21 - 21.27 of this title (relating to Determining Residence Status) or an individual whose Place of Entry into the service, according to military documents, was Texas.

(6) [~~(4)~~] Commissioner--The Commissioner of Higher Education.

(7) Contact hours--A unit of measure that represents an hour of scheduled instruction given to students of which 50 minutes must be of direct instruction. Also referred to as clock hours.

(8) [~~(5)~~] Dependent--An individual who was claimed as a dependent for federal income tax purposes by the individual's parent or court-appointed legal guardian in a particular year and in the previous tax year. A veteran was a dependent if he or she was claimed as such by a parent or legal guardian during the veteran's year of entry into the service and in the previous tax year. A child was a dependent if he or she was claimed as a dependent for tax purposes at the time his or her parent or legal guardian died of injuries or illness directly related to military service.

[~~(6) Discretionary fees--Fees that an institution may, under Texas Education Code, Chapter 54, elect to charge and that, if charged, must be charged to all students who have not been granted a statutory exemption. Discretionary fees do not include optional fees.~~]

(9) Extraordinary costs--(for community/junior colleges only) tuition and fee costs that exceed the average tuition and fee charges at the institution.

(10) Federal survivor benefits--Benefits offered the surviving children of deceased veterans through Title 38, United States Code, Chapter 35.

(11) [~~(7)~~] Hazlewood Act Exemption--The tuition and partial fee exemption authorized under Texas Education Code, §54.203.

(12) [~~(8)~~] Honorably discharged--Released from active duty military service with an Honorable Discharge, General Discharge under Honorable Conditions, or Honorable Separation or Release from Active Duty, as documented by the Certificate of Release or Discharge from Active Duty (DD214) issued by the Department of Defense.

(13) [~~(9)~~] Identification number--An individual's social security number.

(14) [~~(10)~~] Institution--A Texas public institution of higher education as defined in Texas Education Code, §61.003(8).

[~~(11) Mandatory fees--Fees that an institution is required, under Texas Education Code, Chapter 54, to charge all students who have not been granted a specific statutory exemption.~~]

[~~(12) Optional fees--Fees that an institution may, under Texas Education Code, Chapter 54, elect to charge only to those students who choose to use the service or item for which the fees are established.~~]

(15) [~~(13)~~] Property deposit fees--Fees that an institution may, under Texas Education Code, §54.502, elect to charge to insure that institution against losses, damages, and breakage in libraries and laboratories.

(16) [~~(14)~~] Registration, date of--The census date of the term for which the student is applying for the Hazlewood Act Exemption.

(17) [~~(15)~~] Resident of Texas--A resident of the State of Texas as determined in accordance with Chapter 21, §§21.21 - 21.27, of this title (relating to Determining Residence Status).

(18) [~~(16)~~] Student service fees--Fees that an institution may, under Texas Education Code, §§54.503, 54.5061 and 54.513, elect to charge to students to cover the cost of student services.

(19) [~~(17)~~] Training--Time spent as a member of the armed forces that is not included in the "Net Active Service" or the sum of "Net Active Service" indicated on the Certificate of Release or Discharge from Active Duty (DD214) [~~, Items 12(c) and 12(d)~~].

(20) [~~(18)~~] Tuition--All types of tuition that an institution may, under Texas Education Code, Chapter 54, collect from students attending the institution, including statutory tuition, discretionary tuition, [~~flat rate tuition~~], designated tuition, and board-authorized tuition.

§21.2101. Hazlewood Act Exemption.

(a) Subject to the following provisions, an institution shall exempt an eligible veterans or child from the payment of tuition and [~~mandatory and discretionary~~] fees, other than property deposit and student service fees. The exemption shall not apply to the payment of [~~optional~~] fees for services or items that are not required for enrollment in general or for the specific courses taken by the student.

(b) - (f) (No change.)

(g) The governing board of a community college may choose to deny a Hazlewood Act Exemption for a course fee or training fee charged the district to cover flight time costs associated with a course in aircraft flight training for individuals who do not have a private pilot rating or who have a private pilot rating but are not actively seeking to fulfill the requirements of the Federal Aviation Administration for an additional certification or rating. This provision does not apply for terms or semesters beginning in spring 2006 or later.

(h) Beginning with admissions for spring 2006, the governing board of a junior college district may establish a fee for extraordinary costs associated with a specific course or program.

(i) In determining whether to admit a person to any certificate program or any baccalaureate, graduate, postgraduate, or professional degree program, an institution may not consider the fact that the person is eligible for an exemption through this chapter.

§21.2102. Eligible Veterans.

In order to be eligible to receive a Hazlewood Act Exemption, a veteran shall demonstrate that he or she [~~the veteran~~]:

(1) [~~was a resident of Texas~~] at the time he or she entered the service, was a citizen of the United States and

(A) either resided in Texas as indicated by his or her place of entry on a [~~in Item 12 (a) of the person's~~] Certificate of Release or Discharge from Active Duty (DD214); or

(B) was a resident of Texas, as determined in accordance with Chapter 21, §§21.21 - 21.27 of this title (relating to Determining Residence Status).

(2) has been classified as a resident by the institution [~~has been a resident of Texas for at least 12 months before the date of registration (census date)~~] for the term or semester for which the veteran applies for the Hazlewood Act Exemption;

(3) has an honorable discharge from service, general discharge from service under honorable conditions or an honorable separation from service;

(4) has exhausted his or her federal veteran's education benefits, including such benefits as those issued under Title 38, United States Code, Chapters 30, 32, and 35, and Title 10, United States Code, Chapters [~~Chapter~~] 1606 and 1607.

(5) is not in default on an education loan made or guaranteed by the federal government or by the State of Texas [~~a federal or state education loan~~];

(6) has attempted fewer than 150 credit hours using the Hazlewood Act Exemption beginning with [~~since the~~] fall of 1995;

(7) - (8) (No change.)

§21.2103. Eligible Children.

In order to be eligible to receive a Hazlewood Act Exemption, children [~~a child of a veteran~~] shall demonstrate that they [~~the child~~]:

(1) are [~~is a~~] natural or adopted children [~~child~~] of:

(A) members [~~a member~~] of the U.S. Armed Forces who were citizens of the United States and residents [~~was a resident~~] of Texas when they [~~he or she~~] entered the service and who

(i) died while in service, or

(ii) are [~~is~~] missing in action, or

(iii) whose deaths are [~~death is~~] documented to be directly caused by illness or injury connected with service in the armed forces of the United States; or

(B) members [~~a member~~] of the Texas National Guard or Texas Air National Guard who were [~~was~~] killed since January 1, 1946 while on active duty either in the service of Texas or the United States;[~~.~~]

(2) have [~~has~~] exhausted their [~~his or her~~] federal survivor benefits based on the death of a veteran parent; and

(3) are classified by their institutions as residents of Texas [~~has been a resident of Texas for at least 12 months before the date of registration (census date)~~] for the term or semester for which they apply [~~the child applies~~] for the Hazlewood Act Exemption.

§21.2104. The Application.

(a) Board staff shall produce and distribute a state-wide Hazlewood Act Exemption Application, requiring institutions to obtain the following information from applicants for the exemption:

(1) - (2) (No change.)

(3) residency information for the time that the veteran or child wishes to use [~~apply for~~] the exemption,

(4) (No change.)

(5) a statement granting permission to the institution to release current term or semester and historic credit hour information to the Board and granting permission for the Board to share such data with any [~~subsequent~~] institution that the veteran or child might attend.

(b) For an otherwise eligible veteran or child to be entitled to a Hazlewood Act exemption in a given term or semester [~~or term~~], he or she must provide a completed Hazlewood Act Exemption Application and provide the supporting documentation to the institution no later than the registration date of that term or semester.

(c) Beginning Fall 2005, all institutions shall require the completed Hazlewood Act Exemption Application Form with supporting documentation for each exemption that is granted [~~prior to granting the exemption~~].

§21.2105. Supporting Documentation for the Hazlewood Act Exemption Application.

(a) When applying for the first time for the Hazlewood Act Exemption, a veteran shall provide to the institution, along with the Hazlewood Act Exemption Application, the following supporting documentation:

(1) a copy of the veteran's Certificate of Release or Discharge from Active Duty (DD214), [~~and,~~]

(2) [~~if the veteran was released from active duty less than 10 years ago or, if the veteran was a member of the Selected Reserve of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or the Army and Air National Guard less than 14 years ago,~~] proof of the veteran's or reservist's current status regarding eligibility for federal veterans education benefits, and[~~.~~]

(3) documentation of Texas residency at the time the veteran entered the service.

(b) When applying for the first time for the Hazlewood Act Exemption, a child shall provide to the institution, along with the Hazlewood Act Exemption Application, the following supporting documentation:

(1) proof that the parent veteran's death was a result of injury or illness directly associated with service in the U.S. Armed

Forces, or that the National Guard parent was killed [~~veteran's death was a result of injury that occurred~~] while he or she was on active duty either in the service of Texas or the United States;

(2) proof of the child's current status regarding eligibility for federal survivors benefits [~~(not required if the child has received federal survivors benefits for more than 45 months unless the child transfers to a new institution)~~ and];

(3) proof that the child was a dependent of the veteran at the time the veteran died, and [~~.~~]

(4) documentation that the parent was a resident of Texas when he or she entered the service.

§21.2106. Subsequent Hazlewood Exemption Applications.

For each [~~Prior to the census date of a subsequent~~] term or semester of an academic year in which the veteran or child receives a Hazlewood Act Exemption, the institution shall confirm that the veteran or child:

(1) - (2) (No change.)

(3) has exhausted his or her [~~is not currently eligible for~~] federal veterans or survivor's education benefits, and

(4) (No change.)

§21.2107. Release of Data to the Board and Institutions.

Prior to the census date of the first term or semester of an academic year in which the veteran or child receives a Hazlewood Act Exemption, he or she shall execute a statement, consenting to the release of the number of hours taken in the current academic year and in all previous academic years to the Board and to and to any institution that the veteran may attend [~~in the future~~].

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505391
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Proposed date of adoption: January 26, 2006
For further information, please call: (512) 427-6114

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TITLE 22. EXAMINING BOARDS

PART 10. TEXAS FUNERAL SERVICE COMMISSION

CHAPTER 201. LICENSING AND ENFORCEMENT--PRACTICE AND PROCEDURE

22 TAC §201.3

The Texas Funeral Service Commission (Commission) proposes an amendment to Title 22, Part 10, Chapter 201, §201.3, concerning Complaints and Investigations.

The amendment is proposed because Texas Occupations Code §651.202 requires the Commission to adopt rules concerning a complaint to include procedures for the informal and formal hearing process that (1) provide the complainant an opportunity to explain the allegations made in the complaint; (2) provide to the person made the subject of the complaint an opportunity to be heard; and (3) authorize commission staff to dismiss complaints subject to approval by the executive director or the executive director's designee. Existing §201.3 does not outline all procedures in place.

O.C. "Chet" Robbins, Executive Director, has determined that for the first five-year period the amendment is in effect, there will be no fiscal implication for state or local governments as a result of enforcing or administering the proposed amendment.

Mr. Robbins further has determined that for each year of the first five-year period the amendment is in effect, the public benefit anticipated as a result of enforcing the amendment will be eliminating the oral exit interviews in order to expedite the licensure of qualified applicants thereby allowing them to be placed into the community sooner. There will be no effect on large, small or micro-businesses. There is no anticipated economic costs to persons who are required to comply with the amendment as proposed. There is no impact on local employment.

Comments on the proposal may be submitted to Mr. Robbins at P.O. Box 12217, Capitol Station, Austin, Texas 78711-1440, (512) 479-5064 (fax), or electronically to chet.robbins@tfsc.state.tx.us.

The amendment is proposed under Texas Occupations Code, §651.152. The commission interprets §651.152 as authorizing it to adopt rules as necessary to administer Chapter 651.

No other statutes, articles, or codes are affected by the proposal.

§201.3. Complaints and Investigations.

Nothing in this rule shall be deemed to vest substantive or procedural rights in any person. The rule's purpose is twofold: to give affected persons notice of the process the commission follows in the processing of complaints; and to comply with the rulemaking requirements imposed by Texas Occupations Code, §651.202.

(1) Any person may file a complaint with the commission concerning alleged violations of any statute over which the commission has regulatory authority as well as commission rules. Complaints should be addressed to the Commission's address that appears on its website at www.tfsc.state.tx.us.

(2) Staff will provide Complaint forms to a person who wishes to file a complaint. Complaint forms may also printed from the commission's website in both Word and PDF format. The commission-approved form provides space for the following information:

(A) the name and business address of the person or establishment Complained of;

(B) the time and place where the acts occurred;

(C) the nature of the acts set out in sufficient detail to enable the Commission to investigate the complaint and the person or entity complained of to identify the incident and prepare a defense; and

(D) the names, addresses, and telephone numbers of any persons who witnessed the acts;

(3) The form also asks for any pertinent contracts, photographs, letters, advertisements or other documents.

(4) All complaints must be in writing, other than complaints alleging conduct which, if true, would constitute an imminent or continuing threat to the public health, safety, or welfare. These

latter complaints must be reduced to writing before the conclusion of the investigative process.

(5) Complaints are initially referred to an investigator who will acknowledge receipt of the complaint in writing to the complainant. The investigator next will send a copy of the complaint to the respondent by certified mail. The letter of transmittal will request a written narrative response and possibly documents from the respondent within 15 days of receipt of the letter.

(6) The investigator, at the conclusion of the investigation, will prepare a preliminary summary of the allegations, the investigator's findings, and a recommendation for disposition to the executive director.

(7) The director will determine first if the substance of the complaint falls within the commission's jurisdiction. If not, staff will dismiss the complaint, notify the complainant, and possibly refer the matter to an entity having authority over the matter, if the facts show a probable violation of law. If the investigator determines that the facts indicate a probable violation of law or rule over which the commission has regulatory authority, the investigator will prepare a Preliminary Report. This Report will state the facts, upon which it is based and that a violation has occurred. The director will assess the penalty amount based on the disciplinary guidelines described in Texas Administrative Code §201.11.

(8) The investigator will send the person charged with the violation (respondent) a copy of the Preliminary Report and notification of an informal conference.

(9) Staff will send the report by first class mail, return receipt requested, to the respondent's address on file with the Commission.

(10) The executive director presides over informal conferences. The conferences are usually attended by the administrator of compliance and consumer affairs and the investigator who investigated the complaint. The commission's legal counsel may attend. The complainant is entitled to attend the conference as well. In this event the panel typically hears first from the complainant followed by the person charged with the violation. The respondent is entitled to counsel.

(11) No court reporter will be present, the parties will not be placed under oath, and no written record of the conference will be made for use in any subsequent proceeding. The executive director or legal counsel will first explain the process used at the informal conference. The respondent is then given the opportunity to show compliance with all applicable laws and rules.

(12) The conference panel will confer about the complaint following the respondent's presentation. The executive director makes a decision after receiving input from the administrator of compliance and consumer affairs, the investigator, and counsel, if in attendance. The executive director may decide to dismiss the complaint, investigate further, or take disciplinary action. The executive director will give respondent verbal notice of the director's decision at the conclusion of the conference. If the complaint is dismissed, staff will notify the complainant.

(13) The executive director, administrator of compliance and consumer affairs, or the investigator will present a case summary and the executive director's decision to the commission at the next scheduled meeting, unless further investigation is needed. The commission may affirm the executive director's decision made at the informal conference, increase or decrease a penalty imposed, or order further investigation.

(14) Staff will mail notice of the commission's decision to the respondent by first class mail return receipt requested within 10 days of the meeting date to the respondent's address on file with the Commission. If the decision imposes sanctions, respondent shall, within 30 days accept the decision and pay the penalty amount; request a SOAH formal hearing; or request mediation at the SOAH.

(A) Staff will notify the complainant if respondent accepts the decision and pays the penalty imposed.

(B) The Administrative Procedure Act, Texas Government Code Chapter 2001, §2001.051 et.seq and SOAH's Rules of Practice and Procedure, 1 TAC Chapter 155 et. seq govern SOAH formal hearings and subsequent decisions.

(C) The commission's Alternate Dispute Resolution Policy and Procedure Rule 22 TAC §207.1 govern SOAH meditations.

(15) The commission will notify complainants upon the final disposition of any complaint.

(16) The Office of the Attorney General represents the commission before SOAH and in court.

~~[(a) Any person may file a complaint with the commission concerning any licensee's violation of Texas Occupations Code, Chapter 651, the rules promulgated by the commission, Texas Health and Safety Code, Chapters 193, 361, and 711 - 716, or Texas Finance Code, Chapter 154. Staff will furnish a form that a person may use for the purpose of filing a complaint in writing. The form will include space for the following information:]~~

~~[(1) the name and business address of the person or establishment complained of;]~~

~~[(2) the time and place where acts occurred;]~~

~~[(3) the nature of the acts set out in sufficient detail to enable the commission to investigate the complaint and the person or entity complained of to identify the incident and prepare a defense;]~~

~~[(4) the names, addresses, and telephone numbers of any persons who witnessed the acts; and]~~

~~[(5) any pertinent contracts, photographs, letters, advertisements or other documents.]~~

~~[(b) The executive director shall supervise all investigations by the commission, including the investigation of any circumstances involved with the renewal of any license provided for in Texas Occupations Code, Chapter 651.]~~

~~[(c) A person may file a complaint without using the commission's form.]~~

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505355
O.C. Robbins
Executive Director
Texas Funeral Service Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 936-2466

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PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 277. PRACTICE AND PROCEDURE

22 TAC §277.2, §277.6

The Texas Optometry Board proposes amendments to Rules §277.2 and §277.6. The amendments to Rule §277.2 concern changes to the disciplinary proceedings procedure as required by the passage of House Bill 1025, 79th Legislature, Regular Session. The amendments require the attendance of additional board members at informal conferences, provide for informal conferences for persons issued cease and desist orders, require consulting a penalty schedule, and allow the Investigation-Enforcement Committee to enter into an agreed order with a licensee in which the licensee agrees to refund the examination fee paid by the patient.

The amendments to Rule §277.6 concern the publishing of recommended administrative penalties and fines as required by the passage of House Bill 1025, 79th Legislature, Regular Session. The amendments add additional guidelines to those currently in this section, and provide a recommended amount versus a range of administrative penalties and fines.

Chris Kloeris, executive director of the Texas Optometry Board, has determined that for the first five-year period the amendments are in effect there will be no fiscal implications for local government as a result of enforcing or administering the amendments. If additional board members must make additional travel plans, there will be fiscal implications for state government, but the number of additional travel plans needed cannot be accurately determined at this time. The recommended penalty amounts do not markedly differ from the amounts being assessed by the agency at this time.

Chris Kloeris also has determined that for each of the first five years the amendments are in effect, the public benefit anticipated as a result of enforcing the amendments will be that several provisions recommended by the Sunset Review Commission and included in House Bill 1025 will be implemented, including having a wider cross section of the agency participating in the informal conference, the ability of the agency to enter into agreements including a refund of examination fees, the use of a published standardized penalty schedule when determining disciplinary action, and the provision for opportunity to be heard on penalties assessed because of cease and desist orders. Should a licensee enter a settlement agreement that includes a refund of an examination fee, the refund will be an additional cost imposed by the amended statute and rule. Examination fees typically range from $35.00 to $250.00, and it is estimated that one to three refunds will be agreed to each year. The rule provides for an opportunity to contest the imposition of penalties related to a cease and desist order by providing an opportunity to be heard. Choosing to attend the hearing may impose additional costs on a respondent, but such costs will be at the discretion of the respondent who may instead submit written materials. Since the recommended penalty amounts do not markedly differ from the amounts being assessed by the agency at this time, the amendments do not impose additional costs on licensees. Only those licensees found to have violated the Optometry Act and relevant Texas law are subject to the amendments in this section. No disparate impact is foreseen for small or micro businesses. Information may be submitted as comments regarding any possible disparate impact.

Comments on the proposal may be submitted to Chris Kloeris, Executive Director, Texas Optometry Board, 333 Guadalupe Street, Suite 2-420, Austin, Texas 78701-3942. The deadline for furnishing comments is thirty days after publication in the *Texas Register.*

The amendment is proposed under the Texas Optometry Act, Texas Occupations Code, §351.151, §351.551, §351.552, and House Bill 1025, 79th Legislature (Sections 351.507, 351.522 and 351.608 of the Optometry Act). No other sections are affected by the amendments.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession. The Board interprets §351.551 and §351.552 as authorizing the imposition of administrative penalties by the Board according to provisions set out in the Act, and House Bill 1025, 79th Legislature, as revising the required participants of an informal conference and allowing refunds of examination fees, requiring the Board to publish a standardized penalty schedule, and setting the procedure for issuing cease and desist orders.

§277.2. Disciplinary Proceedings.

(a) General statement. In a contested case before the board, proceedings shall be governed by the Administrative Procedure Act (APA), except as specifically provided in the Optometry Act. In any contested case, opportunity shall be afforded to all parties to respond and present evidence and argument on all issues involved. Unless precluded by law, informal disposition may be made of any contested case by stipulation, agreed settlement, consent order, default, refund of examination fees or dismissal.

(b) Informal disposition of contested case. Prior to the imposition of disciplinary sanctions or administrative penalties against a respondent (a licensee or a person issued a cease and desist order), [~~against a licensee,~~] the respondent [~~licensee~~] shall be offered an opportunity to attend an informal conference and show compliance with all requirements of law, in accordance with the APA.

(1) Informal conferences shall be attended by the executive director, the board's legal counsel, the two members [~~a member~~] of the Investigation-Enforcement Committee, a public member, and other representatives of the board as the executive director and legal counsel may deem necessary for the proper conduct of the conference. The respondent [~~licensee~~] and/or the [~~licensee's~~] authorized representative may attend the informal conference and shall be provided an opportunity to be heard.

(2) In any case where charges are based upon information provided by a person who filed a complaint with the board (complainant), the complainant may attend the informal conference, and shall be provided with an opportunity to be heard. Nothing herein requires a complainant to attend an informal conference.

(3) Notice of the informal conference shall include:

(A) a statement of the legal authority, jurisdiction, and alleged conduct under which the enforcement action is based, with a reference to the particular section(s) of the statutes and rules involved;

(B) an offer for the respondent [~~licensee~~] to attend an informal conference at a specified time and place and show compliance with all requirements of law, in accordance with Chapter 2001 of the Administrative Procedure Act;

(C) a statement that the respondent [~~licensee~~] has an opportunity for a hearing before the State Office of Administrative Hearings on the allegations; and

(D) the following statement in capital letters in 12 point boldface type: FAILURE TO RESPOND TO THE ALLEGATIONS, BY EITHER PERSONAL APPEARANCE AT THE INFORMAL CONFERENCE OR IN WRITING, WILL RESULT IN THE ALLEGATIONS BEING ADMITTED AS TRUE AND THE RECOMMENDED SANCTION MADE AT THE INFORMAL CONFERENCE BEING GRANTED BY DEFAULT. The notice shall be served by delivering a copy to the respondent [~~licensee~~] or licensee in person, by courier receipted delivery, or by certified or registered mail, return receipt requested, to the licensee's last known address of record as shown by agency records, not less than 10 days prior to the date of the conference.

(4) The respondent [~~licensee~~] shall respond by either personal appearance at the informal conference or in writing no later than the date of the informal conference. If the respondent [~~licensee~~] chooses to respond in writing, the response shall admit or deny each of the allegations. If the respondent [~~licensee~~] intends to deny only a part of an allegation, the respondent [~~licensee~~] shall specify so much of it is true and shall deny only the remainder. The response shall also include any other matter, whether of law or fact, upon which the respondent [~~licensee~~] intends to rely for his or her defense. If the respondent [~~licensee~~] fails to respond to the notice specified in this subsection, the matter will be considered as a default case and the respondent [~~licensee~~] will be deemed to have:

(A) admitted all the factual allegations in the notice specified in this subsection;

(B) waived the opportunity to show compliance with the law;

(C) waived notice of a hearing;

(D) waived the opportunity for a hearing on the allegations; and

(E) waived objection to the recommended sanctions made at the informal conference.

(5) The Investigation-Enforcement Committee may recommend that the board enter a default order, based upon the allegations set out in the notice specified in this subsection, adopting the recommended sanctions made at the informal conference. Upon consideration of the case, the Board may enter a default order under §2001.056 of the Administrative Procedure Act or direct that the case be set for a hearing at the State Office of Administrative Hearings.

(6) Any default judgment granted under this section will be entered on the basis of the factual allegations in the notice and upon proof of proper notice to the respondent's [~~licensee's~~] address of record as specified in paragraph (3) of this subsection.

(7) A motion for rehearing which requests that the Board vacate its default order under this section shall be granted if the motion presents convincing evidence that the failure to respond to the notice specified in this subsection was not intentional or the result of conscious indifference, but due to accident or mistake, provided that the respondent [~~licensee~~] has a meritorious defense to the factual allegations contained in the notice specified in this subsection and the granting thereof will not result in delay or injury to the public or the Board.

(8) Informal conferences shall not be deemed to be meetings of the board and no formal record of the proceedings at the conferences shall be made or maintained.

(9) The Investigation-Enforcement Committee shall consider the Penalty Schedule in §277.6 of this title (Rule 277.6) to determine the parameters of any administrative fine or penalty to recommend to the respondent and the Board. The Investigation-Enforcement Committee may recommend a settlement to the respondent that includes an agreed order to refund all or part of the examination fee paid by the complainant to the respondent. This settlement must be approved by the Board pursuant to subsection (b)(10).

(10) [~~(9)~~] Any proposed order shall be presented to the board for its review. At the conclusion of its review, the board shall approve, amend, or disapprove the proposed order. Should the board approve the proposed order, the appropriate notation shall be made in the minutes of the board and the proposed order shall be entered as an official action of the board. Should the board amend the proposed order, the executive director shall contact the respondent to seek concurrence. If the respondent does not concur, the provisions of the next sentence shall apply. Should the board disapprove the proposed order, the case shall be rescheduled for purposes of reaching an agreed order or in the alternative forwarded to the State Office of Administrative Hearings for formal action.

(c) - (f) (No change.)

§277.6. Administrative Fines and Penalties.

(a) Based upon the criteria in this section, and in addition to the sanctions listed in subsection (f), the guideline administrative penalty or fine amount for:

(1) felony conviction: $2,000 penalty (Section 351.501(a)(3) of the Act)

(2) misdemeanor conviction involving moral turpitude: $1,000 penalty (Section 351.501(a)(3) of the Act)

(3) impaired ability to practice: $1,500 penalty (Section 351.501(a)(4) of the Act)

(4) violations of the act or rules involving controlled substances: $2,000 penalty (Sections 351.501(a)(4) and (15), 351.358, 351.451, and 351.452 of the Act)

(5) fraud, deceit, dishonesty, or misrepresentation in the practice of optometry or in applying for license; or deceiving, defrauding, or harming the public: $1,500 penalty (Section 351.501(a)(4) and (11) of the Act)

(6) gross incompetence in the practice of optometry or engaging in a pattern of practice or other behavior demonstrating a wilful provision of substandard care: $1,000 penalty (Section 351.501(a)(12) and (13) of the Act)

(7) practicing or attempting to practice optometry while the license is suspended or violating the terms of a Board Order: $1,000 penalty (Section 351.501(a)(8) and (17) of the Act)

(8) having the right to practice optometry suspended or revoked by a federal agency: $1,000 penalty (Section 351.501(a)(10) of the Act)

(9) the guideline administrative penalty or fine amount for the following violations is a $300 penalty:

(A) Failure to report address changes to the Board as required by Sections 351.351 and 351.501(16) of the Texas Optometry Act

(B) Failure to properly display name visible to the public as required by Sections 351.362 of the Act

(C) Failure to display public interest information as required by Section 351.203 of the Act, and §273.9 of this title

(D) Failure to properly release contact lens prescription as required by Section 353.156 of the Contact Lens Prescription Act

(E) Advertising violations, including misleading advertising as prohibited by Sections 351.155 and 351.403 of the Act, and §279.9 of this title

(F) Failure to use proper professional identification as required by Section 104.003 of the Texas Occupations Code

(G) Offering glasses or contact lenses as a prize or inducement as prohibited by Section 351.404 of the Act and §273.3 of this title

(H) Failure of the subject of a complaint to respond within 14 days of receipt to a request letter from the Board regarding the complaint as required by §277.1 of this title

(10) the guideline administrative penalty or fine amount for the following violations is a $750 penalty:

(A) Directing or allowing optical employees or owners to make appointments for a leasing licensee as prohibited by Sections 351.408 and 351.459 of the Act

(B) Directing or allowing optical employees or owners to advertise for a leasing licensee or include the licensee's office in the advertising as prohibited by Sections 351.408 and 351.459 of the Act

(C) Directing or allowing optical employees or owners to set the practice hours for a leasing licensee as prohibited by Section 351.408 of the Act

(D) Practicing in an office not properly separated from a lessor optical as prohibited by Sections 351.363, 351.364, 351.408, and 351.459 of the Act, and §279.12 of this title

(b) [~~(a)~~] In accordance with Section 351.551 of the Texas Optometry Act, administrative penalties may be assessed for violations of the Act or rule or order of the board. Either the executive director or a subcommittee of the board, to include at least one public member of the board, may assess a penalty for each violation and present a report to the board concerning the facts on which the determination was based and the amount of penalty. [~~The range of penalty is $100 to $2,500.~~]

(c) In accordance with Section 351.507 of the Act, the Investigation - Enforcement Committee shall use the guidelines in this rule when determining the appropriate administrative penalty or fine to recommend to the board.

(d) The range of penalty is $100 to $2,500 for each violation.

(e) The guidelines in this rule are intended to promote consistent sanctions for similar violations, facilitate timely resolution of cases, and encourage settlements. The guidelines in this rule apply to a single violation where there are no aggravating or mitigating factors. Multiple violations and aggravating or mitigating factors as listed in subsection (g) may justify a modification of the guideline amount. The guideline amount may be reduced when a respondent acknowledges a violation and agrees to comply with terms and conditions of an agreed order.

(f) The guidelines in this rule apply to administrative penalties and fines. The Board may also, alone or in conjunction with imposing an administrative penalty or fine, refuse to issue a license to an applicant, revoke or suspend a license, place on probation a person whose license has been suspended, impose a stipulation, limitation, or condition relating to continued practice, including conditioning continued practice on counseling or additional education, or reprimand a licensee.

(g) [~~(b)~~] The amount of the penalty shall be based on:

(1) the seriousness of the violation, including nature, circumstances, extent, and gravity of any prohibited act, and hazard or potential hazard created to the health, safety, or economic welfare of the public;

(2) the economic harm to property or the environment caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter future violations;

(5) efforts to correct the violation; and

(6) any other matter that justice may require.

(h) [~~(c)~~] Penalties imposed by the board pursuant to subsections (a) - (g) [~~and (b)~~] of this section may be imposed for each violation subject to the following limitations:

(1) imposition of an administrative penalty not to exceed $2,500 for each violation;

(2) each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.

(i) Administrative penalties or fines for violations not specifically mentioned in this rule shall be based on an amount that corresponds to the scheme of the guidelines of this rule.

[~~(d) Based upon the criteria in subsection (b), the Board may assess a penalty up to the maximum amount listed in each category below for a first violation of the identified prohibited action:~~]

[~~(1) Category 1 Violations: $1,000 maximum penalty~~]

[~~(A) Failure to report address changes to the Board as required by Sections 351.351 and 351.501(16) of the Texas Optometry Act.~~]

[~~(B) Failure to properly display name visible to the public as required by Sections 351.362 of the Act.~~]

[~~(C) Failure to display public interest information as required by Section 351.203 of the Act, and §273.9 of this title.~~]

[~~(D) Failure to properly release contact lens prescription as required by Section 353.156 of the Contact Lens Prescription Act,~~]

[~~(E) Advertising violations, including misleading advertising as prohibited by Sections 351.155 and 351.403 of the Act, and §279.9 of this title.~~]

[~~(F) Failure to use proper professional identification as required by Section 104.003 of the Texas Occupations Code.~~]

[~~(G) Offering glasses or contact lenses as a prize or inducement as prohibited by Section 351.404 of the Act and §273.3 of this title.~~]

[~~(H) Failure of the subject of a complaint to respond within 14 days of receipt to a request letter from the Board regarding the complaint as required by §277.1 of this title.~~]

[~~(2) Category 2 Violations: $2,000 maximum penalty~~]

[~~(A) Directing or allowing optical employees or owners to make appointments for a leasing licensee as prohibited by Sections 351.408 and 351.459 of the Act.~~]

[~~(B) Directing or allowing optical employees or owners to advertise for a leasing licensee or include the licensee's office in the advertising as prohibited by Sections 351.408 and 351.459 of the Act.~~]

[~~(C) Directing or allowing optical employees or owners to set the practice hours for a leasing licensee as prohibited by Section 351.408 of the Act.~~]

[(D) Practicing in an office not properly separated from a lessor optical as prohibited by Sections 351.363, 351.364, 351.408, and 351.459 of the Act, and §279.12 of this title.]

[(3) Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.]

[(4) The board will use the criteria in subsections (a) and (b) to determine the amount of penalty for repeated violations of the acts identified in this subsection and for violations not listed in this subsection.]

(j) [(e)] The provisions of this rule [subsections (a) - (d) of this section] shall not be construed so as to prohibit other appropriate disciplinary action under the Act, civil or criminal action and remedy and enforcement under other laws.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505287
Chris Kloeris
Executive Director
Texas Optometry Board
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 305-8502

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PART 38. TEXAS MIDWIFERY BOARD

CHAPTER 831. MIDWIFERY

The Texas Midwifery Board (board), with the approval of the Executive Commissioner of the Health and Human Services Commission (executive commissioner), proposes amendments to §§831.1 - 831.3, 831.7, 831.121, and 831.131, repeal of §§831.11, 831.31, and 831.161, and new §§831.4, 831.11 - 831.17, 831.20 - 831.23, 831.31 - 831.37, 831.40, and 831.161 - 831.173, concerning the licensing and regulation of midwives.

BACKGROUND AND PURPOSE

The Texas Legislature passed House Bill (HB) 1535, 79th Legislature, Regular Session (2005), Sunset legislation, relating to the continuation and functions of the board; and the licensing and regulation of midwives. A new jurisprudence examination will be administered starting September 1, 2006, for all new applicants for licensure; and once every four years for renewal applicants. A jurisprudence examination fee of $35 will be collected by the contracted agency that is approved by the department. The rules also implement HB 2680, 79th Legislature, Regular Session (2005), relating to reduced fees and continuing education requirements for retired health professionals, including licensed midwives, engaged in the provision of voluntary charity care. Additionally, new language related to emergency suspension was added by Acts 2003, 78th Legislature, Chapter 326, §1.

SECTION-BY-SECTION SUMMARY

Repeal of §831.11 (relating to documentation), §831.31 (relating to education), and §831.61 (relating to complaint review) is being proposed in order to establish new sections which reflect the changes required by recent legislation, agency and reorganization.

New sections in Subchapters A, B, C, D and E are proposed to incorporate existing rule language from the sections being repealed which is still required, and to implement recent legislation.

Amendments to §§831.1 - 831.3, 831.7, 831.121, and 831.131 reflect changes to the Texas Occupations Code, Chapter 203, relating to the changes in the composition of the board, change in terminology from "documentation" to "licensure," and the transfer of the functions of the abolished Board of Health variously to the department, the Commissioner of the Department of State Health Services (commissioner), and the executive commissioner.

Amendments to §831.1 reflect new section names.

Amendments to §831.2 reflect changes required by the abolishment of the "Board of Health"; deletion of "documentation"; and the addition of "Executive Commissioner." The section has been renumbered to reflect deletions and insertions.

Amendments to §831.3 reflect changes required by the abolishment of the Board of Health. The amendments also include changes required by Sunset legislation, including the authority of Commissioner to appoint members to the board and the board chair, and the deletion of the $50 per diem payment to board members in addition to travel reimbursement. Also, the term "chairperson" is shortened to "chair."

New §831.4 reflects the new Sunset legislation requirement for board member training.

Amendments to §831.7 reflect the name change from the Texas Department of Health to the Department of State Health Services.

An amendment to the name of Subchapter B reflects Sunset legislation in the change from "Documentation" to "Licensure."

New §831.11 includes the same rule language related to the requirement for a license previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure.

New §831.12 includes the same rule language related to fees previously included in the section proposed for repeal. The obsolete language related to a one-year term for renewal has been deleted. The section also includes the change in the structure of late fees required by Sunset legislation, the new reduced fee for renewal for a retired midwife providing voluntary charity care required by HB 2680 of $275 for each two year renewal, the new jurisprudence examination fee of $35, and an increase in the site visit fee for approved midwifery courses from $400 to $500 every three years, in order to cover increased travel reimbursement costs associated with conducting the site visit.

New §§831.13 and 831.14 include the same rule language related to application for a license and renewal of a license previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and the new requirement for a jurisprudence examination.

New §831.15 includes the same rule language related to late renewal of a license previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," the new requirement for a jurisprudence examination, and the new one year limit on late renewal.

New §831.16 establishes the standards for renewal of a license with reduced renewal fees and continuing education requirements for a retired midwife providing voluntary charity care as

required by HB 2680. This section defines "retired midwife" and "voluntary charity care," and establishes renewal requirements, late renewal requirements, and requirements for returning a license which was renewed under this section to active status.

New §831.17 includes the same rule language related to state roster previously included in the section proposed for repeal.

New §831.20 includes the same rule language related to grounds for denial of application or disciplinary action previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and the new authority of the board to refuse to renew a license for non-payment of an administrative penalty imposed by the board.

New §831.21 includes the same rule language related to application or renewal with criminal conviction previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and the new requirement for rules specifying the types of criminal convictions that would constitute grounds for board to take action against an individual under Texas Occupations Code, Chapter 53.

New §831.22 includes the same rule language related to surrender of license previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure."

New §831.23 includes the same rule language related to reissuance of license after revocation, suspension or surrender previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure."

An amendment to the name of Subchapter C reflects the new sections covering both education and examination.

New §831.31 includes the same rule language related to the education committee previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and a change in composition due to the new requirement that all committee members be members of the board. The term "chairperson" is shortened to "chair," and the term of appointment for committee members is changed from one year to two years.

New §831.32 includes the same rule language related to basic midwifery education previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and includes revised language allowing a physician licensed in the United States who is actively engaged in the practice of obstetrics to serve as a clinical preceptor for a midwifery student enrolled in an approved course.

New §831.33 includes the same rule language related to education course approval previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure." The term "chairperson" is shortened to "chair."

New §831.34 includes the same rule language related to education course denial or revocation of approval previously included in the section proposed for repeal. The term "chairperson" is shortened to "chair."

New §831.35 includes the same rule language related to exam approval, denial or revocation of approval previously included in the section proposed for repeal. The term "chairperson" is shortened to "chair."

New §831.36 includes the same rule language related to complaints concerning education courses and comprehensive exams previously included in the section proposed for repeal. The term "chairperson" is shortened to "chair."

New §831.37 establishes the standards for the new jurisprudence examination as required by Sunset legislation.

New §831.40 includes the same rule language related to continuing education previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure." It includes language permitting an approved basic midwifery education course to offer continuing education credits to licensed midwives.

Amendments to §831.121 reflect the change from "documentation" to "licensure," as well as corrections to a citation from Texas Revised Civil Statutes to the Texas Occupations Code.

Amendments to §831.131 reflect the change from "documentation" to "licensure."

New §831.161 includes the same rule language related to the complaint review committee previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and a change in composition due to the new requirement that all committee members be members of the board. The term "chairperson" is shortened to "chair." and the term of appointment for committee members is revised from one year to two years.

New §831.162 includes the same rule language related to reporting violations and/or complaints previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure."

New §831.163 includes the same rule language related to records of complaints previously included in the section proposed for repeal.

New §831.164 includes the same rule language related to complaint categories previously included in the section proposed for repeal.

New §831.165 includes the same rule language related to disciplinary action and guidelines previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and in the increase of the maximum administrative penalty from $1,000 to $5,000.

New §831.166 includes the same rule language related to complaint investigation previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure."

New §831.167 includes the same rule language related to informal settlement conferences previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure." The term "chairperson" is shortened to "chair."

New §831.168 includes the same rule language related to hearings previously included in the section proposed for repeal.

New §831.169 includes the same rule language related to disciplinary action previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure," and in the increase in the maximum administrative penalty of up to $5,000 per violation. It includes language authorizing the board to impose either a written warning or a reprimand as a disciplinary action.

New §831.170 includes the same rule language related to complaint disposition and appeals previously included in the section proposed for repeal. It reflects Sunset legislation in the change from "documentation" to "licensure."

New §831.171 reflects Sunset legislation authorizing the board to enter into an agreed order with a midwife, which provides for a refund to the client.

New §831.172 reflects Sunset legislation authorizing the board to issue a cease and desist order, and establishing that a violation of that order is grounds for imposition of an administrative penalty.

New §831.173 implements changes to the Act effective September 1, 2003, related to emergency suspension, including establishing members of the complaint review committee selected the board chair as the three-member committee designated to temporarily suspend a license.

FISCAL NOTE

Kathy Perkins, Manager, Health Care Quality Section, has determined that for each year of the first five-year period that the sections are in effect, there will be minimal fiscal implications to state or local government as a result of enforcing or administering the sections as proposed. The revenue increase of approximately $200 every three years caused by the change in the basic midwifery education course site visit fee will offset the cost of operating the licensing program. The impact of the possible decrease in renewal fees collected due to the implementation of reduced renewal fees for retired midwives over the age of 55 providing voluntary charity care is insignificant due to the extremely small population of licensed midwives (less than 200).

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Perkins has also determined that there will be an effect on small businesses or micro-businesses required to comply with the sections as proposed. The two basic midwifery education courses currently approved in Texas will require an additional $100 every three years for a site visit. There is an anticipated economic cost to persons who are required to comply with the sections as proposed. The $35 jurisprudence examination fee will be required for all new applicants and, once every four years, for renewal applicants. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

In addition, Ms. Perkins has also determined that for each year of the first five years the sections are in effect, the public will benefit from the adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections is to continue to ensure public health and safety through the licensing and regulation of midwives.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the pubic health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Yvonne Feinleib, Midwifery Program Director, Professional Licensing and Certification Unit, Division for Regulatory Services, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756, (512) 834-4521 or by email to midwifery@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

SUBCHAPTER A. THE BOARD

22 TAC §§831.1 - 831.4, 831.7

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Cathy Campbell, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

The proposed amendments and new rule are authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed amendments and new rule affect the Occupations Code, Chapter 203.

§831.1. Introduction.

(a) (No change.)

(b) Construction. These sections cover definitions; the Midwifery Board; board member training; the petition for the adoption of a rule; license required [~~annual documentation~~]; fees; initial application; renewal; late renewal; renewal for retired midwives performing charity work; state midwifery roster; grounds for denial of application or disciplinary action; application or renewal with criminal conviction; surrender of license; reissuance of license after revocation, suspension or surrender; education committee; basic midwifery education; education course approval; education course denial or revocation of approval; exam approval, denial, or revocation of approval; complaints concerning education courses and comprehensive exams; jurisprudence examination; continuing education; standards for the practice of midwifery in Texas; definitions; protocols; termination of the midwife-client relationship; transfer of care in an emergency situation; prenatal care; labor and delivery; postpartum care; newborn and infant care; the administration of oxygen; eye prophylaxis; newborn screening; the informed choice and disclosure statement; the provision of support services; complaint review committee; reporting violations and/or complaints; records of complaints; complaint categories; disciplinary action and guidelines; complaint investigation; informal settlement conferences; hearings; disciplinary action; complaint disposition and appeals; refunds; cease and desist order; and emergency suspension. [~~and complaint review.~~]

§831.2. Definitions.

The following words and terms when used in these sections shall have the following meaning unless the context clearly indicates otherwise:

(1) (No change.)

(2) Appropriate health care facility--The Department of State Health Services, a local health department, a public health district, a local health unit or a physician's office where specified tests can be administered and read, and where other medical/clinical procedures normally take place.

(3) (No change.)

[~~(4) Board--The Texas Board of Health.~~]

(4) [~~(5)~~] Certified nurse-midwife--A registered nurse licensed in Texas, recognized by the Board of Nurse Examiners as an advanced nurse practitioner, and certified by the American College of Nurse-Midwives.

(5) [~~(6)~~] Code--Texas Health and Safety Code.

(6) [~~(7)~~] Commissioner--The Commissioner of the Department of State Health Services.

(7) [~~(8)~~] Department--The [~~Texas~~] Department of State Health Services.

[~~(9) Documentation--The annual process of documenting midwives under the Texas Midwifery Act.~~]

(8) Executive Commissioner--The Executive Commissioner of the Health and Human Services Commission.

(9) [~~(10)~~] Health authority--A physician who administers state and local laws regulating public health under the Health and Safety Code, Chapter 121, Subchapter B.

(10) [~~(11)~~] Local health department--A department of health created by the governing body of a municipality or county under the Health and Safety Code, Chapter 121, Subchapter D.

(11) [~~(12)~~] Local health unit--A division of a municipality or county government that provides limited public health services as provided by the Health and Safety Code, §121.004.

(12) [~~(13)~~] Midwife--A person who practices midwifery under the Texas Midwifery Act and has met the requirements and standards of the Midwifery Board in these sections.

(13) [~~(14)~~] Midwifery--The practice by a midwife of giving the necessary supervision, care, and advice [~~advise~~] to a woman during normal pregnancy, labor and the postpartum period; conducting a normal delivery of a child; and providing newborn care.

(14) [~~(15)~~] Midwifery Board--The Midwifery Board appointed by the Commissioner [~~Texas Board of Health~~].

(15) [~~(16)~~] Newborn care--The care of a child for the first six weeks of the child's life.

(16) [~~(17)~~] Normal childbirth--The labor and delivery at or close to term (37 up to 42 weeks) of a pregnant woman whose assessment reveals no abnormality or signs or symptoms of complications.

(17) [~~(18)~~] Physician--A physician licensed to practice medicine in Texas by the Board of Medical Examiners.

(18) [~~(19)~~] Postpartum care--The care of a woman for the first six weeks after the woman has given birth.

(19) [~~(20)~~] Program--The department's midwifery program.

(20) [~~(21)~~] Public health district--A district created under the Health and Safety Code, Chapter 121, Subchapter E.

(21) [~~(22)~~] Standing delegation orders--Written instructions, orders, rules, regulations or procedures prepared by a physician and designated for a patient population, and delineating under what set of conditions and circumstances actions should be instituted, as described in the rules of the Texas Board of Medical Examiners in Chapter 193 (relating to standing delegation orders).

§831.3. Midwifery Board.

(a) Membership. Members are appointed by the Commissioner [~~Texas Board of Health (board)~~] in accordance with the composition specified by the Texas Midwifery Act. A record of attendance shall be kept at each meeting. If a member misses two consecutive meetings, written notice shall be given to the member. A third consecutive absence from a regularly scheduled meeting shall be grounds for membership termination by the board.

(b) Officers. Midwifery Board officers shall consist of a chair [~~chairperson~~] from one of the public interest members and vice-chair [~~vice-chairperson~~] from any of the other members. The chair is designated by the Commissioner. The vice-chair is [~~officers are~~] selected by [~~at~~] the Midwifery Board [~~Board's first regular meeting, and thereafter~~] as the term of appointment expires [~~terms expire~~] or a vacancy [~~vacancies are~~] otherwise created. The chair shall serve at the pleasure of the Commissioner. The vice-chair [~~Officers~~] shall serve a two-year term [~~terms~~] and shall be eligible for re-election for one additional term. The chair [~~chairperson~~] shall be the presiding officer of the Midwifery Board. The vice-chair [~~vice-chairperson~~] shall assume the authority and duties of the chair [~~chairperson~~] in his/her absence.

(c) (No change.)

(d) Meetings.

(1) Frequency. The Midwifery Board shall meet at least semi-annually and at other times when called by the Midwifery Board or the Commissioner [~~Board~~]. Notice of the time, date, place and purpose of regular meeting shall be provided to the members by mail or by telephone or both, at least seven days in advance of each meeting.

(2) (No change.)

(3) Subcommittees. The subcommittees of the Midwifery Board shall be appointed only from the membership by the chair [~~chairperson~~] with such powers and responsibilities as shall be delegated to them by the chair [~~chairperson~~].

(4) The Midwifery Board chair [~~chairperson~~] may convene ad hoc working groups consisting of board members, licensed [~~documented~~] midwives, consumers, and other stakeholders, as necessary.

(5) Parliamentary procedure. Parliamentary procedures for all Midwifery Board or subcommittee meetings shall be conducted in accordance with the latest edition of Robert's Rules of Order. [~~, except that the chairperson may vote on any actions as any other member.~~] In case of a tie vote, the chair's [~~chairperson's~~] vote will be the tie breaker.

(6) (No change.)

(7) Public participation. All requests from the public to participate in Midwifery Board meetings shall be submitted to the chair [~~chairperson~~]. He or she may approve participation and may limit, as necessary, the time for each participant to address the Midwifery Board. Written comments are encouraged, and may be submitted to the Midwifery Board for its consideration.

(8) Travel Reimbursement. Each [~~Compensatory per diem. Each Midwifery Board member is entitled to receive compensatory per diem in the amount of $50 for each Midwifery Board meeting, or~~

~~subcommittee meeting attended. In addition, each~~] Midwifery Board member is entitled to receive regular per diem and travel allowances as authorized for state employees in accordance with the rate established in the current general appropriations act.

(9) (No change.)

§831.4. Board Member Training.

(a) A person who is appointed to and qualifies for office as a member of the Midwifery Board may not vote, deliberate, or be counted as a member in attendance at a meeting of the Midwifery Board until the person completes a training program that complies with this section.

(b) The training program must provide the person with information regarding:

(1) this chapter and the programs, functions, rules, and budget of the Midwifery Board;

(2) the results of the most recent formal audit of the Midwifery Board;

(3) the requirements of laws relating to open meetings, public information, administrative procedure, and conflicts of interest; and

(4) any applicable ethics policies adopted by the Midwifery Board or the Texas Ethics Commission.

(c) A person appointed to the Midwifery Board is entitled to reimbursement, as provided by the General Appropriations Act, for the travel expenses incurred in attending the training program regardless of whether the attendance at the program occurs before or after the person qualifies for office.

§831.7. Petition for the Adoption of a Rule.

(a) (No change.)

(b) Submission of the petition.

(1) - (3) (No change.)

(4) The petition shall be mailed or delivered to the Texas Midwifery Board, [~~Texas~~] Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756.

(c) - (d) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505404
Brent Baylor
Chair
Texas Midwifery Board
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 458-7236

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SUBCHAPTER B. DOCUMENTATION

22 TAC §831.11

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Midwifery Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The proposed repeal is authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed repeal affects the Occupations Code, Chapter 203.

§831.11. Documentation.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505405
Brent Baylor
Chair
Texas Midwifery Board
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 458-7236

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SUBCHAPTER B. LICENSURE

22 TAC §§831.11 - 831.17, 831.20 - 831.23

The proposed new rules are authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed new rules affect the Occupations Code, Chapter 203.

§831.11. License Required.

(a) In order for an individual to legally practice midwifery in Texas, she/he must be currently licensed by the Midwifery Program.

(b) A midwife license shall be valid for a renewal period of two years starting March 1, 2006, except for initial licensure. A midwife's initial license shall be valid from the date issued until March 1 of the following renewal period.

§831.12. Fees.

All fees should be made payable to the Department of State Health Services and are non-refundable.

(1) Application fee--$275.

(2) Renewal fee--$550 for each two-year renewal period.

(3) Late processing fee (before September 1, 2007)--$125.

(4) Late processing fee (on or after September 1, 2007):

(A) less than 90 days late--a fee that is equal to 1/4 times the amount of the renewal fee due; or

(B) more than 90 days and less than one year late--a fee that is equal to 1/2 times the amount of the renewal fee due.

(5) Retired midwife renewal fee--$275.

(6) Retired midwife reinstatement fee--$275.

(7) Jurisprudence examination fee--$35.

(8) Education course initial application fee--$150.

(9) Education course site visit fee--$500.

(10) For all applications and renewal applications, the department is authorized to collect fees to fund the Office of Patient Protection, Health Professions Council, as mandated by law.

(11) For all applications and renewal applications, the department is authorized to collect subscription and convenience fees, in amounts determined by the Texas Online Authority, to recover costs associated with application and renewal application processing through Texas Online.

§831.13. Initial Application.

(a) Initial licensure. An individual may apply for licensure as a midwife at any time during the year by submitting the following to the Midwifery Program:

(1) a completed licensure application form;

(2) proof of:

(A) satisfactory completion of a mandatory basic midwifery education course approved by the Midwifery Board and the North American Registry of Midwives (NARM) exam or any other comprehensive exam approved by the Midwifery Board;

(B) certified professional midwife (CPM) certification by NARM and satisfactory completion of a continuing education course covering the current Texas Midwifery Basic Information and Instructors Manual; or

(C) satisfactory completion of a basic midwifery education course accredited by the Midwifery Education Accreditation Council (MEAC); a continuing education course covering the current Texas Midwifery Basic Information and Instructors Manual; and the North American Registry of Midwives (NARM) exam or any other comprehensive exam approved by the Midwifery Board;

(3) proof of current cardiopulmonary resuscitation (CPR) certification for health care providers by the American Heart Association or equivalent certification for the professional rescuer from the Red Cross;

(4) proof of current certification for neonatal resuscitation, §§1 - 4, from the American Academy of Pediatrics;

(5) proof of satisfactory completion of training in the collection of newborn screening specimens or an established relationship with another qualified and appropriately credentialed health care provider who has agreed to collect newborn screening specimens on behalf of the applicant;

(6) a nonrefundable application fee; and

(7) proof of passing the jurisprudence examination approved by the Midwifery Board, effective September 1, 2006. The jurisprudence examination must have been taken no more than one year prior to the date of application.

(b) Initial licensure after interim of more than four years. A midwife seeking initial licensure who has not become licensed within four years of completing a basic midwifery education course approved by the Midwifery Board or accredited by MEAC shall provide proof of having completed at least 40 contact hours of approved continuing midwifery education within the year preceding the application, which shall be based upon a review of:

(1) the current Texas Midwifery Basic Information and Instructors Manual; and

(2) the current Midwives Alliance of North America (MANA) Core Competencies and Standards of Practice.

§831.14. Renewal.

License renewal. Licensed midwives must apply for license renewal during the last January of each renewal period. Licensure expires March 1 of the second or last year of the renewal period. The Midwifery Program will send renewal applications to licensed midwives during the last December of each renewal period. However, each midwife is solely responsible for compliance with the requirements for license renewal, and non-receipt of the renewal application mailed by the Midwifery Program shall not constitute an acceptable excuse for failure to comply. A midwife's application for license renewal must include the following:

(1) a completed license renewal application form;

(2) proof of completion of at least 20 contact hours of approved midwifery education since March 1 of the previous two-year renewal period;

(3) proof of current CPR certification for health care providers by the American Heart Association or equivalent certification for the professional rescuer from the Red Cross;

(4) proof of current certification for neonatal resuscitation, §§1 - 4, from the American Academy of Pediatrics;

(5) a nonrefundable renewal fee; and

(6) proof of passing the jurisprudence examination approved by the Midwifery Board in the four years preceding renewal, effective September 1, 2006.

§831.15. Late Renewal.

(a) Late license renewal. A midwife who fails to apply for license renewal by March 1 of the end of a renewal period in which the midwife is currently licensed, as evidenced by a valid United States Postal Service or recognized commercial carrier postmark, may apply for late license renewal on or before March 1 of the following year. Applications for late license renewal must include the following:

(1) each of the items listed in §831.14 of this title (relating to Renewal); and

(2) an additional nonrefundable late processing fee.

(b) A person whose license has been expired for one year or more may not renew the license. The person may obtain a new license by submitting to reexamination and complying with the requirements and procedures for obtaining an initial license.

§831.16. Renewal for Retired Midwives Performing Charity Work.

(a) For the purposes of this subsection, a "retired midwife" is defined as:

(1) currently licensed as a midwife in Texas;

(2) over the age of 55; and

(3) not currently employed in a health care field.

(b) For the purposes of this subsection, "voluntary charity care" is defined as midwifery care provided:

(1) without compensation; and

(2) with no expectation of compensation.

(c) A retired midwife who is not practicing midwifery in Texas, except for providing voluntary charity care, may apply to renew his or her midwifery license under this subsection by submitting all the items required by §831.14 of this title (relating to Renewal) except for the retired midwife renewal fee, not the regular renewal fee.

(d) For subsequent renewals, a retired midwife who is not practicing midwifery in Texas except for providing voluntary charity care may renew his or her midwifery license by submitting all the items required by §831.14 of this title except for:

(1) five hours of continuing education per year of renewal under this subsection, not ten hours; and

(2) the retired midwife renewal fee, not the regular renewal fee.

(e) In order to apply for renew late renewal under this subsection, a retired midwife who is not practicing midwifery in Texas, except for providing voluntary charity care, may renew his or her midwifery license by submitting all the items required by §831.15 of this title (relating to Late Renewal) except for:

(1) five hours of continuing education per year of renewal under this subsection, not ten hours; and

(2) the retired midwife renewal fee, not the regular renewal fee.

(f) A retired midwife who has previously renewed under this subsection, and then subsequently seeks to return to employment in the active practice of midwifery in Texas, must either:

(1) be currently licensed under this subsection but not due for renewal, and submit the following items to the Midwifery Program:

(A) ten hours of continuing education, taken in the 12 months preceding the application;

(B) the retired midwife reinstatement fee; and

(C) a written request to return his or her license to active status; or

(2) be currently licensed under this subsection and when billed for renewal, submit all the items required by §831.14 of this title with a written request to return his or her license to active status; and

(3) receive approval from the Midwifery Program prior to returning to active practice.

§831.17. State Midwifery Roster.

The Midwifery Program shall maintain a roster of all individuals currently licensed to practice midwifery in the state. A copy of the roster shall be provided to each county clerk and local registrar of births on request. The Midwifery Program shall provide information on new and/or late licensees to individual county clerks and local registrars of births during the course of a year as needed.

§831.20. Grounds for Denial of Application or Disciplinary Action.

Grounds for denial of application for licensure or license renewal and for disciplinary action.

(1) The Midwifery Board may deny an application for initial licensure or license renewal and may take disciplinary action against any person based upon proof of the following:

(A) violation of the Act or rules adopted under the Act;

(B) submission of false or misleading information to the Midwifery Board, the board, or the department;

(C) conviction of a felony or a misdemeanor involving moral turpitude;

(D) intemperate use of alcohol or drugs while engaged in the practice of midwifery;

(E) unprofessional or dishonorable conduct that may reasonably be determined to deceive or defraud the public;

(F) inability to practice midwifery with reasonable skill and safety because of illness, disability, or psychological impairment;

(G) judgment by a court of competent jurisdiction that the individual is mentally impaired;

(H) disciplinary action taken by another jurisdiction affecting the applicant's legal authority to practice midwifery;

(I) submission of a birth or death certificate known by the individual to be false or fraudulent, or other noncompliance with Health and Safety Code, Chapter 191, or 25 Texas Administrative Code (TAC), Chapter 181 (relating to Vital Statistics);

(J) noncompliance with Health and Safety Code, Chapter 244, or 25 TAC, Chapter 137 (relating to Birthing Centers);

(K) failure to practice midwifery in a manner consistent with the public health and safety; or

(L) demonstrated lack of personal or professional character in the practice of midwifery.

(2) The Midwifery Board may refuse to renew the license of a person who fails to pay an administrative penalty imposed under Subchapter J of the Act, unless enforcement of the penalty is stayed or a court has ordered that the administrative penalty is not owed.

§831.21. Application or Renewal with Criminal Conviction.

Licensure of persons with criminal conviction.

(1) The Midwifery Board may refuse to issue a license to any individual who has been initially convicted of a felony or a misdemeanor involving moral turpitude, or whose probation imposed pursuant to such conviction has been revoked by the court.

(2) The Midwifery Board shall consider the following factors:

(A) the nature and seriousness of the crime or the reason the applicant's probation was revoked;

(B) any relationship between the crime and the practice of midwifery;

(C) whether licensure might offer the applicant an opportunity to engage in the same or similar criminal activity as that for which the applicant was previously convicted; and

(D) the relationship of the crime to the ability, capacity, or fitness required to perform the duties and discharge the responsibilities of midwifery.

(3) The Midwifery Board, in determining the present fitness of a person who has been convicted of a felony or a misdemeanor involving moral turpitude, shall consider:

(A) the age of the applicant when the crime was committed;

(B) the amount of time that has elapsed since the applicant's conviction;

(C) the applicant's conduct and work history prior to and following the conviction;

(D) evidence of the applicant's progress toward rehabilitation while incarcerated, on probation, or following release; and

(E) other evidence of the person's present fitness, including letters of recommendation from:

(i) prosecutorial, law enforcement, probation, and correctional officers;

(ii) the sheriff or chief of police in the community where the applicant resides; and

(iii) other persons.

(4) Specific offenses for which a conviction would constitute grounds for the Midwifery Board to take action under Occupations Code, §53.021, because these criminal offenses indicate an inability or a tendency to be unable to practice midwifery in a manner consistent with public health, safety or welfare include:

(A) a violation of the Act;

(B) an offense related to misconduct or fraud in the provision of health care or which occurred in a health care facility;

(C) an offense involving the misuse or abuse of drugs or alcohol;

(D) an offense related to falsification of, or tampering with, a government document;

(E) an offense related to birth certificate fraud, or attempting to obtain citizenship through fraud;

(F) a misdemeanor involving deceptive business practices;

(G) the offense of assault or sexual assault;

(H) the felony offense of theft; or

(I) any other misdemeanor or felony which would indicate an inability or a tendency to be unable to practice midwifery in accordance with Subchapter D of this chapter (relating to Practice of Midwifery).

§831.22. Surrender of License.

(a) A midwife may surrender his or her license prior to its expiration for the current period by mailing the original license acknowledgment letter back to the Midwifery Program together with a signed statement of his or her intent to surrender same.

(b) Surrender of license by a midwife after receipt of notification from the Midwifery Program that a complaint against the midwife is being investigated shall not deprive the Midwifery Board of jurisdiction in any disciplinary action which may result from said investigation.

(c) The Midwifery Board may enter any disciplinary order authorized by the Act or this subchapter to resolve a complaint against a midwife who has surrendered his or her license after receipt of notification from the Midwifery Program that a complaint is being investigated.

§831.23. Reissuance of License after Revocation, Suspension, or Surrender.

(a) A person whose license to practice midwifery in this state has been revoked or suspended by the Midwifery Board or who has surrendered his or her license after having received notice that the Midwifery Program is investigating a complaint may not apply for reissuance of license until the applicant has complied with all requirements imposed by the Midwifery Board in connection with the revocation, suspension, or surrender. If the Midwifery Board denies the application for reissuance of license, an applicant may request a hearing in accordance with the provisions of the Administrative Procedure Act (APA), Government Code, Chapter 2001, applicable state and federal statutes, the Rules of Practice and Procedures of the State Office of Administrative Hearings (SOAH) and this chapter. The decision of the hearing examiner shall be final.

(b) The Midwifery Board may reissue a license to a midwife who surrendered his or her license while an investigation or disciplinary action was pending only if the Midwifery Board finds that:

(1) the applicant is competent to resume practice; and

(2) the Midwifery Program has no evidence of current or continuing violations by the applicant of the Act or this subchapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505406
Brent Baylor
Chair
Texas Midwifery Board
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 458-7236

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SUBCHAPTER C. EDUCATION

22 TAC §831.31

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Midwifery Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The proposed repeal is authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed repeal affects the Occupations Code, Chapter 203.

§831.31. Education.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505407
Brent Baylor
Chair
Texas Midwifery Board
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 458-7236

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SUBCHAPTER C. EDUCATION AND EXAMINATION

22 TAC §§831.31 - 831.37, 831.40

The proposed new rules are authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed new rules affect the Occupations Code, Chapter 203.

§831.31. Education Committee.

(a) The chair of the Midwifery Board shall appoint an education committee for a two year term, with the approval of the Midwifery Board, to consider all issues related to mandatory basic and continuing midwifery education. The Education Committee shall review all applications submitted by the Midwifery Program staff for approval of mandatory basic midwifery education courses or comprehensive exams, as well as complaints concerning approved courses or exams. The Education Committee will consist of members of the Midwifery Board:

(1) two licensed midwives, one of whom shall serve as chair;

(2) a physician; and

(3) a public interest member.

(b) The Midwifery Board chair may convene ad hoc working groups consisting of committee members, licensed midwives, and other interested individuals, as necessary.

(c) Except for informal settlement conferences, all other meetings and proceedings of the Education Committee shall be open to the public.

§831.32. Basic Midwifery Education.

(a) The Midwifery Program staff shall consider for approval only courses which have a course supervisor/administrator and site in Texas.

(b) Mandatory basic midwifery education shall:

(1) be offered to ensure that only trained individuals practice midwifery in Texas;

(2) be offered by any individual or organization meeting the requirements for course approval established by this subsection;

(3) include a didactic component which shall:

(A) be based upon and completely cover the most current Core Competencies and Standards of Practice of the Midwives Alliance of North America (MANA) and the current Texas Midwifery Basic Information Manual;

(B) prepare the student to apply for certification by North American Registry of Midwives (NARM); and

(C) include a minimum of 250 hours course work.

(4) be supervised and conducted by a course supervisor/administrator who shall:

(A) be responsible for all aspects of the course; and

(B) have two years of experience in the independent practice of midwifery, nurse-midwifery or obstetrics; and

(C) have been primary care giver for at least 75 births including provision of prenatal, intrapartum, and postpartum care; and

(D) have met initial licensure requirements; or

(E) be a Certified Professional Midwife (CPM); or

(F) be American College of Nurse Midwives (ACNM) certified; or

(G) be a licensed physician in Texas actively engaged in the practice of obstetrics.

(5) include didactic curriculum instructors who:

(A) have training and credentials for the course material they will teach; and

(B) are approved by the course supervisor/administrator.

(6) provide clinical experience/preceptorship of at least one year in duration and equivalent to 1360 clinical contact hours which prepares the student to become certified by NARM, including successful completion of at least the following activities:

(A) serving as an active participant in attending 20 births;

(B) serving as the primary midwife, under supervision, in attending 20 additional births, at least 10 of which shall be out-of-hospital births;

(C) serving as the primary midwife, under supervision, in performing:

(i) 75 prenatal exams, including at least 20 initial history and physical exams;

(ii) 20 newborn exams; and

(iii) 40 postpartum exams.

(7) include preceptors who are approved by the course supervisor/administrator and shall be:

(A) licensed midwives;

(B) certified professional midwives;

(C) certified nurse midwives; or

(D) physicians licensed in the United States and actively engaged in the practice of obstetrics.

(c) Individuals enrolled as students in an approved midwifery course must possess:

(1) a high school diploma or the equivalent; and

(2) a current cardiopulmonary resuscitation (CPR) certificate for health care providers from the American Heart Association or an equivalent CPR certificate for the professional rescuer from the Red Cross.

§831.33. Education Course Approval.

(a) Course approval.

(1) The course supervisor/administrator shall submit an application form and a non-refundable initial midwifery course application fee to the Midwifery Program with the following supporting documentation:

(A) course outline;

(B) course curriculum with specific content references to:

(i) MANA Core Competencies;

(ii) NARM Written Test Specifications;

(iii) NARM Skills Assessment Test Specifications; and

(iv) Texas Midwifery Basic Information Manual.

(C) identification of didactic and preceptorship teaching sites;

(D) a financial statement or balance sheet (within the last year) for the course supervisor/administrator or course owner and disclosure of any bankruptcy within the last five years; and

(E) written policies to include:

(i) tuition schedule, other charges, and cancellation and refund policy, including the right of any prospective student to cancel his/her enrollment agreement within 72 hours after signing the agreement and receive a full refund of any money which may have paid;

(ii) student attendance, progress, and grievance policies;

(iii) rules of operation and conduct of school personnel;

(iv) requirements for state documentation;

(v) disclosure of approval status of course;

(vi) maintenance of student files; and

(vii) reasonable access for non-English speakers and compliance with federal and state laws on accessibility.

(2) Student files shall be maintained for a minimum of five years and shall include:

(A) evidence that the entrance requirements have been met;

(B) documentation demonstrating completion of didactic and clinical course work; and

(C) copies of any financial agreements between the student and the school.

(3) The Midwifery Program staff and Education Committee chair shall review each course application submitted for approval. If an application for initial approval meets all of the requirements specified in this paragraph, a one-year provisional approval will be granted. An on-site evaluation of the course shall be scheduled. The evaluation shall be conducted by a member of the Midwifery Program staff and a licensed midwife within the provisional year. The midwife member of the evaluation team shall be appointed by the chair of the Midwifery Board and shall not be the supervisor, didactic instructor, or preceptor of another basic midwifery education course in the same geographic area. The site visit will include the following:

(A) an inspection of the course's facilities;

(B) a review of its teaching plan, protocols, and teaching materials;

(C) a review of didactic and preceptorship instruction;

(D) interviews with staff and students; and

(E) a review of student files.

(4) A non-refundable site visit fee shall be assessed for each course approval site visit.

(5) The review team's written report shall conclude with a recommendation to the Education Committee for approval or denial of the course.

(6) The Education Committee shall evaluate the application and all other pertinent information, including any complaints received and the on-site review team's report and recommendation.

(7) The Midwifery Board shall consider the application and the recommendations of the Education Committee and shall render a final decision during the provisional year. The decisions of the Education Committee and Midwifery Board shall be based upon the criteria specified in this subsection.

(8) Each applicant shall be notified of the Midwifery Board's decision in writing within ten working days. If an application is denied, the notification shall specify the reason(s) for denial.

(b) Course reciprocity. A basic midwifery education course which is currently accredited by the Midwifery Education Accreditation Council (MEAC) shall be deemed approved under this subsection upon submission of evidence of such accreditation.

(c) Duration of course approval.

(1) The Midwifery Board shall approve courses for a three-year period.

(2) Course supervisors/administrators shall reapply for approval six months prior to expiration.

(d) Course changes. Any substantive change(s) in the course or its content shall be submitted to the Midwifery Program staff prior to the change(s) if known in advance or within ten working days after change(s). The Midwifery Program staff shall notify the Education Committee chair. The Midwifery Board may reconsider the status of any course which has undergone substantive changes should the course no longer meet the requirements of this subchapter.

§831.34. Education Course Denial or Revocation of Approval.

(a) Appeal of course denial. An appeal of a notification of a denial must be submitted in writing to the chair of the Midwifery Board through the Midwifery Program within 21 working days of the applicant's receipt of the notice. Upon receipt of the appeal, the appellant will be placed on the agenda of the next scheduled meeting of the Midwifery Board, at which time the appellant may appear and the Board shall render a decision on the appeal.

(b) Revocation of course approval. The Midwifery Board may revoke the approval of a course after notifying the course supervisor/administrator of its intended action and the opportunity for an appeal, if the Midwifery Board determines that:

(1) the course no longer meets the standards established by this subsection;

(2) the course supervisor, instructor(s), or preceptor(s) do not have the qualifications required by this subsection;

(3) course approval was obtained by fraud or deceit;

(4) the course supervisor has falsified course registration, attendance, and/or completion records; or

(5) continued approval of the course is not in the public interest as defined by the Midwifery Board.

(c) Notice and hearings required under this subsection will be conducted in accordance with the provisions of the Administrative Procedure Act (APA), Government Code, Chapter 2001, applicable state

and federal statutes, the Rules of Practice and Procedures of the State Office of Administrative Hearings (SOAH) and this chapter.

(d) An administrative law judge (ALJ) appointed by the SOAH shall preside over and conduct the hearing. A formal hearing shall be held in Travis County, Texas, unless otherwise determined by the ALJ or upon agreement of the parties.

(e) After the hearing, the ALJ shall prepare a proposal for decision and provide copies of same to all parties to the hearing.

(f) All proposals for decision shall be referred to the Midwifery Board for final decision.

§831.35. Exam Approval, Denial, or Revocation of Approval.

Comprehensive exams.

(1) Comprehensive exam approval.

(A) Any approved education course or midwifery association may submit an application form and a non-refundable exam initial application fee to the Midwifery Program with the following supporting documentation:

(i) copy of exam;

(ii) copy of all exam information and preparation materials, including sample test booklet(s);

(iii) evidence that the written portion of the examination has been validated by an independent professional, as required by the Act, §11(b);

(iv) references to the MANA Core Competencies included in the exam;

(v) identification of proposed test sites;

(vi) a financial statement or balance sheet (within the last year) for the course supervisor/administrator or course owner or midwifery association and disclosure of any bankruptcy within the last five years; and

(vii) written policies to include:

(I) charge for exam administration, other charges, and cancellation and refund policy;

(II) confidentiality of individual exam scores;

(III) administration and grading of exam;

(IV) requirements for test sites and proctors;

(V) disclosure of approval status of exam;

(VI) complaint procedures;

(VII) maintenance of exam files; and

(VIII) reasonable access for non-English speakers and compliance with federal and state laws on accessibility.

(B) Separate exam files for each administration of the exam shall be maintained for a minimum of five years and shall include:

(i) evidence of identity of all test takers, and of all proctors;

(ii) documentation concerning exam administration procedures;

(iii) copies of any financial agreements related to the administration of the exam;

(iv) copies of any complaints received;

(v) copies of exam(s) administered; and

(vi) originals of all scored exams.

(C) The Midwifery Program staff and Education Committee chair shall review each exam application submitted for approval. If an application for approval meets all of the requirements specified in this paragraph, it will be forwarded to the Education Committee within 60 days.

(D) The Education Committee shall evaluate the application and recommend either approval or denial of the application to the Midwifery Board.

(E) The Midwifery Board shall consider the application and the recommendations of the Education Committee and shall render a final decision.

(F) Each applicant shall be notified of the Midwifery Board's decision in writing within ten working days. If an application is denied, the notification shall specify the reason(s) for denial.

(2) Appeal of exam denial. An appeal of a notification of a denial must be submitted in writing to the chair of the Midwifery Board within 21 working days of the applicant's receipt of the notice. The appellant may appear at the next scheduled meeting of the Midwifery Board, at which the Board shall render a decision on the appeal.

(3) Duration of exam approval.

(A) The Midwifery Board shall approve exams for a three-year period;

(B) Any revisions to the exam must be approved according to the requirements of this subsection; and

(C) Course supervisors/administrators or associations of midwifery shall reapply for approval six months prior to expiration.

(4) Exam changes/revisions. Any substantive change(s) in, or revisions to, the exam, its administration, or any of the policies associated with it, shall be submitted to the Midwifery Program staff prior implementation of the change(s), along with a explanation for the proposed change(s). The Midwifery Program staff shall notify the Education Committee chair. The Midwifery Board may reconsider the status of any exam in which substantive changes have been made.

(A) The Education Committee may request and consider any relevant information, including exam files, when reconsidering course approval.

(B) The Education Committee shall forward its recommendations to the Midwifery Board.

(5) Revocation of exam approval.

(A) The Midwifery Board may revoke the approval of an exam after notifying the course supervisor/administrator or course owner or midwifery association of its intended action and the opportunity for an appeal, if the Midwifery Board determines that:

(i) the exam or the course/association who submitted it for approval no longer meets the standards established by this subsection;

(ii) exam approval was obtained by fraud or deceit;

(iii) records required by this subsection have been falsified or are incomplete;

(iv) exam files or other relevant information have been withheld from the Midwifery Board or Education Committee despite a written request; or

(v) continued approval of the exam is not in the public interest as defined by the Midwifery Board.

(B) Each course supervisor/administrator or midwifery association shall be notified of the Midwifery Board's decision in writing within ten working days. If an application is denied, the notification shall specify the reason(s) for denial.

(C) Notice and hearings required under this subsection will be conducted in accordance with the provisions of the Administrative Procedure Act (APA), Government Code, Chapter 2001, applicable state and federal statutes, the Rules of Practice and Procedures of the State Office of Administrative Hearings (SOAH) and this chapter.

(D) An administrative law judge (ALJ) appointed by the SOAH shall preside over and conduct the hearing. A formal hearing shall be held in Travis County, Texas, unless otherwise determined by the ALJ or upon agreement of the parties.

(E) After the hearing, the ALJ shall prepare a proposal for decision and provide copies of same to all parties to the hearing.

(F) All proposals for decision shall be referred to the Midwifery Board for final decision.

(6) Complaints. If a complaint cannot be resolved by the complaint process associated with the exam, the complainant may file a complaint against the exam or the course supervisor/administrator or course owner or midwifery association with the Education Committee in accordance with the procedures in §831.36 of this title (relating to Complaints Concerning Education Courses and Comprehensive Exams).

§831.36. Complaints Concerning Education Courses and Comprehensive Exams.

(a) Report of a complaint. Complaints may be accepted by the Midwifery Program by telephone, in person, or in writing from any person or agency alleging violations of this section.

(1) The Midwifery Program staff shall mail a letter and complaint form to the complainant within ten working days of being notified of the complaint. The complaint form shall request at least the following information:

(A) the name, address, and telephone number of complainant (optional);

(B) the name, address, and telephone number of course supervisor/administrator or course owner or midwifery association that is the subject of the complaint;

(C) a complete statement of the complaint, including date(s), time(s), and location(s) of event(s);

(D) the name, address, and telephone number of any witnesses; and

(E) a description of any other reporting, filing, or attempted resolution of the complaint.

(2) The complaint review process begins when the completed complaint form is received by the Midwifery Program and assigned a case number, and the subject of the complaint is determined to be a course or exam approved under this section.

(3) If the complaint form includes the complainant's name and address, the complainant shall be notified in writing of the Midwifery Program's receipt of the complaint form within ten working days.

(b) Records of complaints. The Midwifery Program shall maintain an information file about each complaint. The information file shall be kept current and shall contain, if applicable:

(1) the written complaint;

(2) a record of all persons contacted in relation to the complaint;

(3) client records;

(4) other requested records;

(5) a summary of findings;

(6) an explanation of the legal basis and the Midwifery Board's reason for dismissing a complaint;

(7) sanctions imposed; and

(8) other relevant information.

(c) Complaint investigation. The Midwifery Program Director shall:

(1) notify the course supervisor/administrator or course owner or midwifery association of the Midwifery Program's receipt of the complaint by certified mail;

(2) request all relevant records necessary to conduct an investigation of the complaint;

(3) interview the complainant, the respondent, and any witnesses;

(4) review and evaluate all information received;

(5) forward the complaint to any other agencies or organizations which may also have jurisdiction and/or refer the complainant to said agencies or organizations;

(6) present each complaint to the Education Committee; and

(7) notify the course supervisor/administrator or course owner or midwifery association by certified mail of the date and time of the Education Committee at which the complaint will be presented, at least 30 days in advance.

(d) Settlement conference. The Education Committee chair or, in his/her absence, the vice-chair, will preside over and conduct the conference.

(1) On the day and time designated for the conference, the chair or vice-chair shall:

(A) state the purpose of and the legal authority for the conference; and

(B) outline the procedure and order of presentation to be followed.

(2) Order of presentation. After making the necessary introductory and explanatory remarks, the chair or vice-chair shall state the case number and the nature of the complaint.

(A) The Education Committee shall review all available evidence from the investigation, including any statements from the complainant and the course supervisor/administrator or course owner or midwifery association. The Education Committee may question any person present regarding relevant information. Whether or not the complainant or course supervisor/administrator or course owner or midwifery association is present, the settlement conference shall proceed with the information on hand.

(B) Evidence and statements shall be reviewed by the Education Committee and one of the following recommendations made to the Midwifery Board:

(i) close the complaint file due to insufficient evidence; or

(ii) enter an agreed order.

(C) Complaints not resolved by settlement conference shall be referred for a hearing.

(e) Hearings.

(1) All administrative hearings under this section shall be conducted in accordance with the provisions of the Administrative Procedure Act (APA), Government Code, Chapter 2001, applicable state and federal statutes, the Rules of Practice and Procedures of the State Office of Administrative Hearings (SOAH) and this chapter.

(2) An administrative law judge (ALJ) appointed by the SOAH shall preside over and conduct the hearing. A formal hearing shall be held in Travis County, Texas, unless otherwise determined by the ALJ or upon agreement of the parties.

(3) After the hearing, the ALJ shall prepare a proposal for decision and provide copies of same to all parties to the hearing.

(4) All proposals for decision shall be referred to the Midwifery Board for final decision.

(f) Guidelines for sanctions. The Midwifery Board/Education Committee shall consider the following factors in imposing sanctions:

(1) the severity of the offense;

(2) the damage to the public or to the profession of midwifery;

(3) the number of repetitions of the offense;

(4) the length of time since date of offense;

(5) the number of sanctions imposed upon the course supervisor/administrator or course owner or midwifery association;

(6) the length of time the course or exam has been offered;

(7) the actual injury, financial or otherwise, suffered by the student(s) or person(s) taking the exam;

(8) any efforts at rehabilitation or remediation by the course supervisor/administrator or course owner or midwifery association; and

(9) any other mitigating or aggravating circumstances.

(g) Penalties and Sanctions. If the Midwifery Board finds that a course supervisor/administrator or course owner or midwifery association has violated this subsection, it shall enter an order imposing one or more of the following:

(1) a written warning or reprimand;

(2) limitation or restriction of course or exam approval for a specified time;

(3) suspension of course or exam approval for a specified time;

(4) revocation of course or exam approval;

(5) probation of any sanction imposed on the course supervisor/administrator or course owner or midwifery association;

(6) acceptance by the Midwifery Board of the voluntary surrender of approval and without the opportunity for reinstatement unless the Midwifery Board determines the course supervisor/administrator or course owner or midwifery association is competent to resume offering the course or exam; or

(7) imposition of conditions for approval that the course supervisor/administrator or course owner or midwifery association must satisfy before the Midwifery Board issues an unrestricted approval.

(h) Failure to cooperate. Failure to provide records requested by the Midwifery Program, without good cause shown, shall be grounds for additional disciplinary action.

(i) Disposition.

(1) Agreed disposition.

(A) The Midwifery Board may, unless precluded by law or this section, make a disposition of any complaint by agreed order.

(B) An agreed disposition is considered a disciplinary order for purposes of reporting under this chapter and of administrative hearings and proceedings by state and federal regulatory agencies regarding the practice and education of licensed midwives. An agreed order is a public record. In civil or criminal litigation, an agreed disposition is a settlement agreement under Texas Rules of Civil Evidence, Rule 408, and Texas Rules of Criminal Evidence, Rule 408.

(2) Closed file. The Midwifery Board may close the complaint file due to insufficient evidence.

§831.37. Jurisprudence Examination.

(a) The department shall develop a draft jurisprudence examination and present it to the Midwifery Board for approval.

(b) The subject matter covered by the examination shall include the Act, this chapter, and other Texas laws which affect midwifery practice, as described in the current Texas Midwifery Basic Information and Instructors Manual.

(c) The department shall review and update the examination as needed, subject to the approval of the Midwifery Board.

(d) The examination shall be administered in a web-based format through an examination contract, which specifies that applicants for examination must be able to:

(1) pay the examination fee online by credit card; and

(2) receive their examination results electronically immediately upon completion of the examination.

(e) If requested in writing by a person who fails an examination administered under this chapter, the Midwifery Board shall furnish the person with an analysis of the person's performance on the examination.

§831.40. Continuing Education.

All continuing education taken by midwives for the purpose of obtaining or renewing a midwifery license must be in accordance with this section.

(1) Mandatory continuing midwifery education courses support the need for midwives practicing in Texas to maintain current knowledge and skills.

(2) Courses may be offered by any individual or organization that meets the requirements for course approval established by this section.

(3) Course curriculum must provide an educational experience which:

(A) covers new developments in the fields of midwifery or related disciplines; or

(B) reviews established knowledge in the fields of midwifery or related disciplines; and

(C) shall be presented in standard contact hour increments for continuing health education; and

(D) shall provide reasonable access for non-English speakers and comply with federal and state laws on accessibility.

(4) Course coordinators and instructors.

(A) Course coordinators shall obtain course approval, register and certify participant attendance, and provide attendance certificates to participants following the course.

(B) Course instructors shall have training and credentials appropriate for the course material they will teach.

(5) Course approval. Continuing education courses attended to fulfill licensure requirements shall be accepted when the courses:

(A) satisfy the requirements of paragraph (3)(A) - (C) of this section; and

(B) are accredited by one of the following accrediting bodies:

(i) a professional midwifery association, nursing, social work, or medicine;

(ii) a college, a university, or an approved basic midwifery education course;

(iii) a nursing, medical, or health care organization;

(iv) a state board of nursing or medicine;

(v) a department of health; or

(vi) a hospital.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Brent Baylor
Chair
Texas Midwifery Board
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For further information, please call: (512) 458-7236

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SUBCHAPTER D. PRACTICE OF MIDWIFERY

22 TAC §831.121, §831.131

The proposed amendments are authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed amendments affect the Occupations Code, Chapter 203.

§831.121. Newborn Screening.

(a) Each midwife who assists at the birth of a child is responsible for seeing that newborn screening tests are performed according to the Health and Safety Code, Chapters 33 and 34, and 25 Texas Administrative Code §§37.51-37.69 (relating to Newborn Screening Program). The midwife may perform the tests or refer for them. If she or he does them, then she or he must have been appropriately trained. Each midwife must have one of the following documents on file with the midwifery program in order to be licensed [~~documented~~].

(1) Midwife Training Certification Form for Newborn Screening Specimen Collection. Should the midwife choose to do the newborn screening she or he will obtain training to perform this test from an appropriate health care facility. Instruction will be based upon the procedure for newborn screening developed by the department's Newborn Screening Program under authority of the Health and Safety Code, Chapter 33. At the completion of the instruction for newborn screening blood collection, the midwife will request that the form Midwife Training Certification Form for Newborn Screening Specimen Collection be signed by the designated representative of the health care facility, attesting to the fact that the midwife has complied with this requirement. This training, as part of the licensure [~~documentation~~] requirements, is only necessary once unless there is a change in screening procedures.

(2) (No change.)

(b) As long as the midwife has been approved to perform the newborn screening test, the act of collecting this specimen will not constitute "practicing medicine" as defined by the Medical Practice Act, Texas Occupations Code, §151.002(13) [~~Texas Civil Statutes, Article 4495b, §1.03(a)(12)~~].

(c) (No change.)

§831.131. Informed Choice and Disclosure Statement.

As required by the Act, §203.351 (relating to Informed Choice and Disclosure Requirements), each midwife shall disclose in oral and written form to a prospective client the limitations on the skills and practices of the midwife. The written informed choice and disclosure statement which has been approved by the Midwifery Board shall include:

(1) an informed choice statement containing:

(A) (No change.)

(B) the date of expiration of the midwife's license [~~documentation~~];

(C) - (E) (No change.)

(2) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER E. COMPLAINT REVIEW

22 TAC §831.161

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Midwifery Board or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The proposed repeal is authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed repeal affects the Occupations Code, Chapter 203.

§831.161. Complaint Review.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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22 TAC §§831.161 - 831.173

The proposed new rules are authorized by the Texas Occupations Code, §203.151, which provides that, subject to the approval of the Executive Commissioner of the Health and Human Services Commission, the Midwifery Board shall adopt substantive and procedural rules for the licensing of midwives and minimum standards for the practice of midwifery, including educational requirements, complaint and disciplinary procedures, reciprocity of licensing with other states, and such other duties as may be imposed by the Texas Occupations Code, Chapter 203.

The proposed new rules affect the Occupations Code, Chapter 203.

§831.161. Complaint Review Committee.

Complaint Review Committee. With the approval of the Midwifery Board, the chair of the Midwifery Board shall appoint a Complaint Review Committee for two-year terms to consider all complaints filed against licensed midwives and to make recommendations to the Midwifery Board.

(1) The Complaint Review Committee shall consist of the following Midwifery Board members:

(A) two licensed midwives, one of whom shall serve as the chair;

(B) a physician; and

(C) a public interest member.

(2) The Midwifery Board chair may appoint ad hoc working groups consisting of committee members, licensed midwives, and other persons as necessary.

(3) During the investigation and consideration of a complaint, the Complaint Review Committee shall schedule an informal conference to discuss the investigation and to consider any recommendations for disposition of the complaint. At no time shall the Complaint Review Committee or Midwifery Board disclose the identity of the midwife's client.

§831.162. Reporting Violations and/or Complaints.

Report of a complaint. Any person or agency may contact the Midwifery Program by telephone, in person, or in writing, alleging that a licensed midwife has violated the Act, any provisions of this subchapter, or any other law or rule relating to the practice of midwifery in Texas.

(1) Midwifery Program staff shall provide a complaint form to the complainant by mail within ten working days of being contacted by the complaint.

(2) The complaint review process begins when:

(A) the complaint form is received by the Midwifery Program;

(B) the Midwifery Program confirms that the subject of the complaint is a midwife licensed in Texas and/or practicing midwifery in Texas;

(C) the Midwifery Program confirms that the complaint alleges acts which took place not more than five years before the receipt of the complaint; and

(D) the Midwifery Program assigns a case number.

(3) If the complainant has provided his or her name and address, the Midwifery Program shall confirm receipt of the complaint form in writing within ten working days.

§831.163. Records of Complaints.

Records of complaints. The Midwifery Program shall maintain the following information concerning each complaint filed, if applicable:

(1) a copy of the complaint;

(2) record of all persons contacted in relation to the complaint;

(3) client records;

(4) other records requested during the investigation;

(5) a summary of findings;

(6) basis for recommending dismissal of the complaint;

(7) disciplinary action taken; and

(8) other relevant information.

§831.164. Complaint Categories.

(a) The Midwifery Program Director shall assign a category for each complaint for the initial allocation of investigative resources in accordance with Midwifery Board policy.

(b) The final complaint category shall be assigned by the Complaint Review Committee after completion of the investigation.

§831.165. Disciplinary Action and Guidelines.

(a) The Midwifery Board and the Complaint Review Committee shall consider the following factors when taking or recommending disciplinary action:

(1) the severity of the offense;

(2) the danger to the public;

(3) the number of repetitions of offenses;

(4) the length of time since date of violation;

(5) any other disciplinary actions taken against the midwife;

(6) the length of time the midwife has practiced;

(7) the extent of the client's injuries, physical or otherwise;

(8) any efforts at rehabilitation or remediation by the midwife;

(9) prior determinations by the Midwifery Board that a midwife has violated the Act and/or rules; and

(10) any other mitigating or aggravating circumstances.

(b) In addition to or in lieu of the penalties and sanctions under §831.169(a) of this title (relating to Disciplinary Action), the following administrative penalties shall be used in recommending disposition of complaints involving the following violations:

(1) for intentional alteration or falsification of birth or death certificates; revocation of licensure and an administrative penalty not to exceed $5,000;

(2) for intentional alteration or falsification of client records or reports, other than birth or death certificates, or misrepresentation of facts:

(A) for the first offense, an administrative penalty not to exceed $100;

(B) for a second offense, an administrative penalty not to exceed $200; and

(C) for subsequent offenses, an administrative penalty not to exceed $500 per offense, with each day of a continuing violation constituting a separate violation.

(3) for failure to submit, upon request, to the Midwifery Program any records or reports relating to the practice of midwifery required under the Act:

(A) for the first offense, an administrative penalty not to exceed $100;

(B) for a second offense, an administrative penalty not to exceed $200; and

(C) for subsequent offenses, an administrative penalty not to exceed $500 per offense, with each day of a continuing violation constituting a separate violation;

(4) for violations of Subchapter D of this chapter (relating to Practice of Midwifery):

(A) for the first offense, an administrative penalty not to exceed $200;

(B) for a second offense, an administrative penalty not to exceed $400; and

(C) for a subsequent offense:

(i) an administrative penalty not to exceed $5,000 per offense, with each day of a continuing violation constituting a separate violation; and

(ii) license revocation;

(5) for practicing midwifery without a license, with a lapsed license, or while licensure has been suspended or revoked, the Midwifery Board may request that the attorney general or a district, county, or city attorney institute a civil action in district court to collect a civil penalty not to exceed $250 per offense, with each day of a continuing violation constituting a separate violation;

(6) for procuring or renewing a license through fraud:

(A) denial of license; and

(B) an administrative penalty not to exceed $5000 per offense, with each day of a continuing violation constituting a separate violation;

(7) for failure to practice midwifery in a manner consistent with public health and safety:

(A) denial of license;

(B) suspension of license; or

(C) revocation of license;

(8) for all other violations of the Act and/or rules not covered by this subsection: disciplinary sanctions determined on a case by case basis.

(c) Failure by a midwife to practice midwifery in a manner consistent with public health and safety shall include, but shall not be limited to:

(1) making deceptive or fraudulent representations in the practice of midwifery, including, but not limited to false claims of proficiency in any field;

(2) mistreating a client, including, but not limited to:

(A) verbal or physical abuse of client;

(B) abandonment immediately before or during labor; or

(C) repeated failure to appear at scheduled appointments without canceling, except in an emergency situation;

(3) exploiting the client and/or her family by engaging in a sexual relationship or misconduct during the provision of midwifery care;

(4) using or maintaining a work area, equipment, or clothing that is unsanitary, except in an emergency situation;

(5) failing to supervise midwifery students or apprentices in his/her charge effectively;

(6) using fraud in the practice of midwifery, practicing midwifery with gross incompetence, with gross negligence on a particular occasion, or with a pattern of fraud, negligence, or incompetence;

(7) willfully failing to inform or misleading a client who requests the name, mailing address, or telephone number of the Midwifery Program for the purpose of filing a complaint; or

(8) failing to provide a written explanation of charges previously made on a bill or statement in response to the client's written request.

§831.166. Complaint Investigation.

(a) The Midwifery Program Director or director's designee shall:

(1) notify the midwife of the complaint by certified mail within ten working days of reading the complaint;

(2) obtain all relevant midwifery records and medical records necessary to conduct an investigation of a complaint without the necessity of consent of the midwife's client;

(3) interview the complainant, the respondent, and any witnesses;

(4) obtain any available peer review reports;

(5) review and evaluate all information received;

(6) forward complaint(s) not within the Midwifery Board's jurisdiction to other agencies and/or refer complainants to appropriate agencies;

(7) present each complaint to the Complaint Review Committee; and

(8) notify the midwife by certified mail of the category initially assigned to the complaint and the date and time of the Complaint Review Committee meeting at which the complaint will be considered, at least 30 days in advance. The midwife shall be afforded an opportunity to present relevant evidence and to show compliance with all requirements of law for the retention of licensure.

(b) The Midwifery Board shall periodically notify the parties of the status of the complaint until final disposition of the complaint.

§831.167. Informal Settlement Conferences.

The Complaint Review Committee chair shall conduct the conference. If the chair is absent, the vice-chair shall preside.

(1) The chair or vice-chair shall:

(A) state the legal authority for and the purpose of the conference; and

(B) outline the procedure to be followed.

(2) Order of presentation. After explaining the purpose of the conference and other related matters, the chair or vice-chair shall state the case number and the nature of the complaint.

(A) The Complaint Review Committee shall review all information obtained during the investigation and any statements from the complainant and/or the midwife. The Complaint Review Committee may question any person present regarding relevant information.

(B) The midwife shall be afforded an opportunity to present relevant evidence and to show compliance with all requirements of law for the retention of licensure.

(C) Following review of all evidence and statements, the Complaint Review Committee shall make one of the following recommendations to the Midwifery Board:

(i) closure of the complaint due to insufficient evidence; or

(ii) entry of an agreed order.

(D) Matters not resolved by settlement conference shall be referred for a hearing.

§831.168. Hearings.

(a) All administrative hearings under this subchapter shall be conducted in accordance with the provisions of the Administrative Procedure Act (APA), Government Code, Chapter 2001, applicable state and federal statutes, the Rules of Practice and Procedures of the State Office of Administrative Hearings (SOAH) and this chapter.

(b) An administrative law judge (ALJ) appointed by the SOAH shall preside over and conduct the hearing. A formal hearing shall be held in Travis County, Texas, unless otherwise determined by the ALJ or upon agreement of the parties.

(c) After the hearing, the ALJ shall prepare a proposal for decision and provide copies of same to all parties to the hearing.

(d) All proposals for decision will be referred to the Midwifery Board for final decision.

§831.169. Disciplinary Action.

(a) Penalties and sanctions. If the Midwifery Board finds a person has violated the Act and/or rules adopted under the Act or any other law or rule relating to the practice of midwifery in Texas, it shall enter an order imposing one or more of the following:

(1) denial of the person's application for licensure;

(2) issuance of a written warning or reprimand;

(3) limitation or restriction of the midwife's practice for a specified time;

(4) suspension of the midwife's license for a specified time;

(5) revocation of the midwife's license;

(6) required participation by the midwife in counseling and treatment for psychological impairment, or intemperate use of alcohol or drugs;

(7) required participation by the midwife in one or more education programs;

(8) required practice by the midwife under the direction of a preceptor for a specified period;

(9) probation of any penalty imposed;

(10) acceptance of the voluntary surrender of a midwife's license, but without reissuance of license unless the Midwifery Board determines the midwife is competent to resume practice;

(11) imposition of conditions for reinstatement that the midwife must satisfy before the Midwifery Board reissues a license following suspension, revocation, or voluntary surrender; or

(12) assessment of an administrative penalty against not to exceed $5,000 for each violation, with each day of a continuing violation constituting a separate violation.

(b) Failure to cooperate. Failure to provide records requested by the Midwifery Program in the course of a complaint investigation, without good cause shown, shall constitute grounds for additional disciplinary action.

§831.170. Complaint Disposition and Appeals.

(a) The Midwifery Board may, unless precluded by law or this section, make a disposition of any complaint by agreed order.

(b) An agreed disposition is considered a disciplinary order for purposes of reporting under this chapter and of administrative hearings and proceedings by state and federal regulatory agencies regarding the practice of licensed midwives. An agreed order is a public record. In civil or criminal litigation, an agreed disposition is a settlement agreement under Texas Rules of Civil Evidence, Rule 408, and Texas Rules of Criminal Evidence, Rule 408.

(c) The Midwifery Board may close the complaint due to insufficient evidence.

§831.171. Refunds.

(a) In addition to other disciplinary action authorized by the Act or this chapter, the Midwifery Board may order a licensed midwife

to pay a refund to a consumer as provided in an agreement resulting from an informal settlement conference instead of or in addition to imposing an administrative penalty under this chapter.

(b) The amount of a refund ordered as provided in an agreement resulting from an informal settlement conference may not exceed the amount the consumer paid to the licensed midwife for a service regulated by this chapter. The Midwifery Board may not require payment of other damages or estimate harm in a refund order.

§831.172. Cease and Desist Order.

(a) If it appears to the Midwifery Board that a person who is not licensed under this chapter is violating the Act, this section, or another state statute or rule relating to the practice of midwifery, the Midwifery Board, after notice and opportunity for a hearing, may issue a cease and desist order prohibiting the person from engaging in the activity.

(b) A violation of an order under this section constitutes grounds for the imposition of an administrative penalty.

§831.173. Emergency Suspension.

(a) The Midwifery Board or a three-member committee of Midwifery Board members designated by the Midwifery Board shall temporarily suspend the license of a documented midwife if the Midwifery Board or committee determines from the evidence or information presented to it that continued practice by the licensed midwife would constitute a continuing and imminent threat to the public welfare.

(b) Any three members of the Complaint Review Committee selected by the Midwifery Board chair, or in the chair's absence, the vice-chair, may serve as the three-member committee unless a different three member committee is designated by the Midwifery Board.

(c) A license may be suspended under this section without notice or hearing on the complaint if:

(1) action is taken to initiate proceedings for a hearing before the State Office of Administrative Hearings simultaneously with the temporary suspension; and

(2) a hearing is held as soon as practicable under this chapter and Government Code, Chapter 2001.

(d) The State Office of Administrative Hearings shall hold a preliminary hearing not later than the 14th day after the date of the temporary suspension to determine if there is probable cause to believe that a continuing and imminent threat to the public welfare still exists. A final hearing on the matter shall be held not later than the 61st day after the date of the temporary suspension.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 21. TRADE PRACTICES

SUBCHAPTER J. PROHIBITED TRADE PRACTICES

28 TAC §21.1004

The Texas Department of Insurance proposes new §21.1004 concerning the use of residential property insurance claims in rating programs, including surcharge and claims-free programs. The new section is necessary to implement amendments enacted under Senate Bill 14 (SB 14), by the 79th Legislature, Regular Session, to Insurance Code Article 5.43 (relating to optional premium discounts for certain residential property insurance policies) and §551.107 (relating to premium surcharges for residential property insurance policies). SB 14 amended various provisions of Chapter 5 of the Insurance Code, including Articles 5.144, 5.171, 5.43, and §551.107. The SB 14 amendments, in part, harmonize Article 5.43 and §551.107 by amending Article 5.43 to include the identical language in §551.107 to identify claims that cannot be used as residential property insurance claims in rating programs whether the claims are considered for a surcharge, discount, or claims-free program. The proposed new section does not prohibit or limit insurers of residential property insurance from considering these claims in the development of base rates. Additionally, as insurers continue to transition from the benchmark rate system under former Insurance Code Article 5.101 to the more flexible file and use system under Article 5.13-2, proposed §21.1004 establishes a procedure to promote rate stability and avoid rate shock by requiring insurers to file a transition plan when a new rating program is introduced or an existing rating program is changed.

Proposed §21.1004(a) specifies the purpose of the new section which is to protect homeowners in Texas from drastic increases in residential property insurance rates and premiums as a result of the introduction of or changes to a claims-free program or claim surcharge program and to promote rate stability for the residential property insurance market in Texas. Proposed subsection (a) also specifies that the new section applies to rates applicable to residential property insurance policies that are delivered, issued for delivery, or renewed on or after January 1, 2006. Proposed §21.1004(b) further implements the SB 14 amendments to Article 5.43 and §551.107 by defining terms commonly used in residential property insurance rating programs. Proposed §21.1004(c) prohibits insurers from assigning a premium consequence for certain claims incurred on or after September 1, 2005, and paragraphs (1) - (3) specify those claims that may not result in a premium consequence because they are not residential property insurance claims for purposes of Insurance Code §551.107 and Article 5.43 as provided in those statutes. Under SECTION 8 of SB 14, the amendments to Article 5.43 and §551.107 became effective September 1, 2005. However, under SECTION 7 of the bill, the amendments apply only to rates applicable to insurance policies that are delivered, issued for delivery, or renewed on or after January 1, 2006. Proposed §21.1004(d) and (e) specify that claims-free and premium surcharge rating programs utilized by residential property insurers are subject to the filing requirements of §5.9332. Proposed §21.1004(f) requires residential property insurers to file a transition plan if they introduce a new or change an existing rating program that con-

siders a policyholder's claim experience, and paragraphs (1) - (3) set forth the transition plan requirements.

C.H. Mah, Senior Associate Commissioner, Property and Casualty Program, has determined that for each year of the first five years the proposed section will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Mr. Mah has further determined that for each year of the first five years the proposed section is in effect, the public benefits anticipated as a result of the proposed section will be a uniform and efficient utilization of claims in residential property insurance rating programs. Additionally, the proposed section will establish guidelines for a transition plan that will promote rate stability and avoid rate shock to homeowners. There should be no measurable economic cost to persons required to comply with the proposed section. Any costs to insurers complying with new §21.1004(a) - (c) each year of the first five years the proposal will be in effect are the result of the legislative enactment of SB 14, and any cost to insurers complying with new §21.1004(d) and (e) will not represent additional or new expenses since insurers are required to submit this rate information in accordance with Insurance Code Article 5.13-2. The cost of complying with §21.1004(f) should not result in additional expenses to insurers because they already develop, consider, and file their own rating information with the department and, under the proposal, should only need to submit an explanation of their plan for moderating increases. The costs of submitting an explanation in order to comply with this section will not vary between the smallest and largest businesses because both small and large insurers alike maintain their own rating information and will be able to review and consider that information in order to file a plan for moderating increases when necessary. Accordingly, the proposed amendments will not have a disproportionate impact on small and micro businesses. The department has considered the purpose of SB 14 and the proposed section, which is to provide for a uniform and efficient utilization of claims in residential property insurance rating programs and to thereby promote rate stability and avoid rate shock to all homeowners. Thus, it is neither legal nor feasible to waive the requirements of the proposed section for small or micro-businesses because to do so would create a conflict between the department's rules and the statute.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on January 2, 2006 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to J'ne Byckovski, Mail Code 105-5F, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a public hearing should be submitted separately to the Office of the Chief Clerk.

The new section is proposed under the Insurance Code Articles 5.13-2, 5.43, 5.35-4, and §551.107 and §36.001. Article 5.13-2, §5(a) and (a-1) provide that insurers shall file with the Commissioner all rates, applicable rating manuals, supplementary rating information, and additional information as required by the Commissioner for risks written in this state. SB 14, enacted by the 79th Legislature, Regular Session, amended various provisions of Chapter 5 of the Insurance Code, including Articles 5.144, 5.171, 5.43, and §551.107. The SB 14 amendments, in part, harmonize Article 5.43 and §551.107 by amending Article 5.43 to include the identical language in §551.107 to identify claims that cannot be used as residential property insurance claims in rating programs whether the claims are considered for a surcharge, discount, or claims-free program. Article 5.43 provides that the Commissioner shall adopt rules as necessary to implement the article and shall establish by rule guidelines for insurers to develop discounts based on sound actuarial principles. One of the SB 14 amendments added a provision to §551.107 that the Commissioner shall adopt rules as necessary to implement the section. Article 5.35-4 §3 requires underwriting guidelines relating to a water damage claim or claims used by an insurer to be governed by rules adopted by the Commissioner and provides that an insurer may not use such an underwriting guideline that is not in accordance with rules adopted by the Commissioner in accordance with the purpose of Article 5.35-4. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The following sections are affected by this proposal: Insurance Code Article 5.43 and §551.107

§21.1004. Restrictions on Certain Claims in Residential Property Insurance and Transition Plan Requirement.

(a) Purpose and Applicability. The purpose of this section is to protect homeowners in Texas from drastic increases in residential property insurance rates and premiums due to the introduction of, or changes to, a claims-free program or claim surcharge program and to promote rate stability for the residential property insurance market in Texas. This section also identifies certain claims that may not be used as residential property insurance claims under Insurance Code Article 5.43 and §551.107. This section applies to the rates applicable to residential insurance policies that are delivered, issued for delivery, or renewed on or after January 1, 2006.

(b) Definitions for the purposes of this section.

(1) Residential property insurance--Property or property and casualty insurance covering a dwelling, including homeowner's insurance, residential fire and allied lines insurance, farm and ranch insurance, or farm and ranch owners insurance.

(2) Premium surcharge--An additional amount due to a policyholder's claims experience that is added to the base rate. The term does not include a reduction or elimination of a discount previously received by an insured, reassignment of an insured from one rating tier to another, re-rating an insured, or re-underwriting an insured by using multiple affiliates.

(3) Claims-free program--Any program that considers a policyholder's claim experience whether through the use of discounts, a tier classification, or other program that does not qualify as a premium surcharge if the policyholder has continuously been a residential property insurance policyholder with that insurer or an affiliate of that insurer.

(4) Transition plan--A plan that promotes rates and premiums that are fair, just, and reasonable by moderating rate and premium increases caused by the introduction of, or change to, a claims-free or claim surcharge program, including a tier classification system.

(5) Natural cause claim--A weather claim.

(6) Claim that is filed but is not paid or payable--A claim that is filed, including a customer inquiry, that does not result in an indemnity payment under the provisions of the policy.

(c) Premium consequence prohibited. An insurer may not assign any premium consequence through a premium surcharge or claims-free program based on claims incurred on or after September 1, 2005, in whole or in part, due to

(1) claims resulting from a loss caused by natural causes;

(2) a claim that is filed but not paid or payable under a residential property policy; or

(3) a claim that an insurer is prohibited from using under Insurance Code Article 5.35-4 §3 and §21.1007 of this title (relating to Restrictions on the Use of Underwriting Guidelines Based On a Water Damage Claim(s), Previous Mold Damage or a Mold Damage Claim(s)).

(d) Claims-free programs. Claims-free programs must be based on sound actuarial principles. Actuarial support as specified in §5.9332 of this title (relating to Filing Requirements) must be filed with the department in the event such program is introduced or changed.

(e) Premium surcharge programs. Premium surcharge program experience must be based on sound actuarial principles. Actuarial support as specified in §5.9332 of this title must be filed with the department in the event such program is introduced or changed.

(f) Transition plan required. If an insurer introduces a new method or changes an existing method of considering, utilizing, reviewing, or otherwise evaluating a policyholder's claim experience, including a tier classification, for the purpose of rating and issuing residential property insurance, a transition plan is required and must be filed with the department. The transition plan shall:

(1) be reasonable and promote market and rate stability;

(2) take into consideration any changes other than claims history that may impact overall rates; and

(3) moderate or otherwise mitigate overall rate and premium increases for individual policyholders over one or several renewal periods.

(g) Termination clause. Subsection (f) of this section expires January 1, 2009.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505399
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-6327

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 380. ALTERNATIVE DISPUTE RESOLUTION

The Texas Water Development Board (board) proposes amendments to 31 TAC Chapter 380, Alternative Dispute Resolution. Specifically, the board proposes to amend §§380.4, 380.22, and 380.24. These amendments are proposed in order to make the rules consistent with House Bill 1940, 79th Legislature, Regular Session (2005).

The board proposes to amend §380.4 to add a sentence stating that a contractor is not prevented from asserting a counterclaim or right of offset against the board if the board has filed suit against the contractor in court. This addition is in response to a similar change House Bill 1940 made to §2260.005, Government Code. The proposed amendment tracks the language of House Bill 1940.

The board proposes an amendment to §380.22(d) to change the deadline for delivering notice of any counterclaim to the contractor from 90 days to 60 days. This proposed amendment is in response to the same timetable change House Bill 1940 made to §2260.051, Government Code. The proposed amendment tracks the language of House Bill 1940.

The board also proposes an amendment to §380.24(b) to state that negotiations will begin no later than the 120th day after the date the contractor's notice of claim is received. This proposed amendment is in response to the deadline change House Bill 1940 made to §2260.052, Government Code. The proposed amendment tracks the language of House Bill 1940. The board also proposes to delete §380.24(c) due to the fact that the statutory language that this was based on was repealed by House Bill 1940. Specifically, House Bill 1940 repealed §3360.052(b), Government Code, so that state agencies are no longer able to delay the beginning of negotiations until after the 180th day after the date of the event giving rise to the claim. The board proposes amending §380.24(d) - (h). First, the subsections will be relettered to account for the deletion of §380.24(c). Second, the deadline for the parties to agree to mediation or another form of assisted negotiations will be changed from 270 days to 120 days. This amendment is proposed in response to the same deadline change House Bill 1940 made to §2260.056, Government Code. The proposed amendment tracks the language of House Bill 1940.

The board proposes amending the relettered §380.24(d) and (f) to correct the citation to §380.24(f). Due to the proposed deletion of §380.24(c), the correct citation should now be §380.24(e).

Lastly, the board proposes amending relettered §380.24(g) to correct the citation to subsections (b) and (c). Due to the board proposing to delete subsection (c), the citation should only be to subsection (b).

Pursuant to §2001.024, Government Code, James LeBas, Chief Financial Officer, has determined that, for the first five-year period the amendments are in effect, there are no additional estimated costs or lost revenues for state or local governments as a result of enforcing or administering the amended sections. There are also no estimated reductions in costs or increased revenues for state and local governments as a result of enforcing or administering the amended sections. Enforcing or administering the amended sections does not have any foreseeable implications relating to cost or revenues for state and local governments.

Pursuant to §2001.024, Government Code, Mr. LeBas has also determined that, during the first five years the amendments, as

proposed, are in effect the public benefit anticipated as a result of enforcing the proposed amendments is that disputes over state contracts will be more efficiently resolved.

Pursuant to §2006.002, Government Code, Mr. LeBas has determined that there is no adverse economic effect on small or micro-businesses as a result of enforcing or administering the amended sections. Further, pursuant to §2001.022, Government Code, Mr. LeBas has determined that these proposed amendments have no effect on local economies. There is no anticipated economic cost to persons who are required to comply with the amendments as proposed. There is no anticipated effect on local employment in geographic areas affected by these proposed amendments.

Comments on the proposal may be directed to Ron Pigott, Acting Deputy General Counsel, P.O. Box 13231, Austin, Texas 78711-3231, by e-mail at Ron.Pigott@twdb.state.tx.us, or by fax at (512) 463-5580. Comments will be accepted for 30 days following the date of publication of this proposal in the *Texas Register*.

SUBCHAPTER A. GENERAL PROVISIONS

31 TAC §380.4

Ron Pigott, Acting Deputy General Counsel, certifies that the proposed amendments have been reviewed by legal counsel and found to be within the state agencies' authority to adopt. These amendments are proposed under the Texas Water Code, §6.101 and §16.053, which authorizes the board to adopt administrative rules necessary to carry out the regional water planning process.

The statutory provision affected by the proposed amendments is Texas Government Code, Chapter 2260.

§380.4. Prerequisites to Suit.

The procedures contained in this chapter are exclusive and required prerequisites to suit under Texas Civil Practice & Remedies Code, Chapter 107, and Texas Government Code, Chapter 2260. These rules do not prevent a contractor sued by the board from asserting a counterclaim or right of offset against the board in the court in which the board filed suit.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505272
Ron Pigott
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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SUBCHAPTER B. NEGOTIATION OF CONTRACT DISPUTES

31 TAC §380.22, §380.24

Ron Pigott, Acting Deputy General Counsel, certifies that the proposed amendments have been reviewed by legal counsel and found to be within the state agencies' authority to adopt. These amendments are proposed under the Texas Water Code, §6.101 and §16.053, which authorizes the board to adopt administrative rules necessary to carry out the regional water planning process.

The statutory provision affected by the proposed amendments is Texas Government Code, Chapter 2260.

§380.22. Agency Counterclaim.

(a) - (c) (No change.)

(d) The notice of counterclaim shall be delivered to the contractor no later than 60 [~~90~~] days after the board's receipt of the contractor's written notice of claim for breach of contract.

(e) (No change.)

§380.24. Timetable.

(a) (No change.)

(b) The [~~Except as provided by subsection (c) of this section, the~~] parties shall begin negotiations no later than the 120th [~~60th~~] day after [~~following the later of:~~]

[~~(1) the date of termination of the contract;~~]

[~~(2) the completion date in the original contract; or~~]

[~~(3)~~] the date the board received the contractor's notice of claim.

[~~(c) The board may delay negotiations until after the 180th day after the date of the event giving rise to the claim for breach of contract by:~~]

[~~(1) delivering written notice to the contractor that the commencement of negotiations will be delayed; and~~]

[~~(2) delivering a second written notice to the contractor when the board is ready to begin negotiations.~~]

(c) [~~(d)~~] The parties may conduct negotiations according to an agreed schedule as long as they begin negotiations no later than the deadline [~~deadlines~~] set forth in subsection [~~subsections~~] (b) [~~or (c)~~] of this section[~~, whichever is applicable~~].

(d) [~~(e)~~] Except as provided by subsection (e) [~~(f)~~] of this section, if a claim is not entirely resolved through negotiations, mediation, or any other assisted negotiation process utilized by the parties by the 270th day after the date that the notice of claim was received by the board, the contractor may file a written request for a contested hearing pursuant to §380.29 of this chapter (relating to Request for Contested Case Hearing).

(e) [~~(f)~~] The parties may agree in writing to extend the time for negotiations, mediation, or any other assisted negotiation process on or before the 270th day after the board received the contractor's written notice of claim for breach of contract. The agreement shall be signed by representatives of the parties with authority to bind each respective party and shall state the final date of the extension period. The parties may enter into a series of written extension agreements that comply with the requirements of this section. If the claim is not entirely resolved at the end of the agreed upon extension period, the contractor may file a written request for a contested hearing pursuant to §380.29 of this chapter.

(f) [~~(g)~~] The parties may agree to mediate the dispute or use any other assisted negotiation process at any time before the 120th [~~270th~~] day after the board received the contractor's written notice of claim or before the expiration of any extension agreed to by the parties pursuant to subsection (e) [~~(f)~~] of this section. The mediation or other

assisted negotiation process shall be governed by Subchapters C and D of this chapter.

(g) [~~(h)~~] Nothing in this section is intended to prevent the parties from agreeing to commence negotiation, mediation, or any other assisted negotiation process earlier than the deadline [~~deadlines~~] established in subsection [~~subsections~~] (b) [~~and (c)~~] of this section, or from continuing or resuming such processes after the contractor has requested a contested case hearing.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505273
Ron Pigott
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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CHAPTER 382. WATER INFRASTRUCTURE FUND

The Texas Water Development Board (the board) proposes amendments to 31 TAC §§382.1, 382.3 and 382.22 concerning Water Infrastructure Fund. The amendments are proposed for cleanup and clarification as a result of the four-year rule review requirement of Texas Government Code §2001.039.

The board proposes an amendment to §382.1, Scope of Chapter, to change the Subchapter of Chapter 15 of the Texas Water Code under which the Water Infrastructure Fund is established, from Subchapter O to Subchapter Q. This amendment is consistent with a change to Chapter 15 of the Texas Water Code made by House Bill 3505 of the 78th Legislature, Regular Session (2003).

The board proposes an amendment to §382.3, Use of Funds, to delete the current text of §382.3(c), which limits funding to political subdivisions for planning and design costs, permitting costs, and other costs associated with state or federal regulatory activities with respect to a project to no more than 10% of financial assistance budgeted by the board to be made available from the Water Infrastructure Fund in a fiscal year. This proposed amendment is consistent with a change to the §15.974 of the Texas Water Code made by Senate Bill 509 of the 79th Legislature, Regular Session (2005).

Current §382.22(b)(1)(L)(iii) requires that the applicant submit an affidavit from its authorized representative that states that there is no pending or threatened litigation against the applicant that would materially adversely affect the financial condition of the applicant or to issue the debt. The board proposes amending this subsection by adding the requirement that the affidavit that either there is no pending or threatened judgments, orders, or fines from the Texas Commission on Environmental Quality or any other federal, state, or local government, or to identify any such judgments, orders, or fines. The reason that the board proposes this amendment is that the board currently requires this information as part of its Drinking Water State Revolving Fund Program and that by including this requirement in this program, the board develops consistency between its program requirements. Also, the board believes that as a state agency it should be aware of incidents of non-compliance by the applicant with the other arms of government prior to approving financial assistance to an applicant.

James LeBas, Chief Financial Officer, has determined that for the first five-year period the amendments are in effect, there will not be fiscal implications on state and local government as a result of enforcement and administration of the amended sections.

Mr. LeBas also determined that for the first five years these sections, as proposed, are in effect, the public benefit anticipated as a result of enforcing the proposed amendments will be a greater understanding of Board rules. Mr. LeBas has determined there will not be economic costs to small businesses or individuals required to comply with the amendments as proposed.

Comments on the proposal will be accepted for 30 days following publication and may be submitted to Srin Surapanani, Attorney, General Counsel Office, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, by e-mail to srin.surapanani@twdb.state.tx.us or by fax at (512) 463-5580.

SUBCHAPTER A. INTRODUCTORY PROVISIONS

31 TAC §382.1, §382.3

The amendments are proposed under the authority of the Texas Water Code §6.101, which provide the Texas Water Development Board with the authority to adopt rules necessary to carry out the powers and duties in the Texas Water Code and other laws of the State, and Texas Water Code §15.977 which requires the Board to adopt rules relating to the Water Infrastructure Fund.

Cross reference to statute: Water Code, Chapter 15, Subchapter Q.

§382.1. Scope of Chapter.

This chapter shall govern applications for financial assistance from the Water Infrastructure Fund, established by the Texas Water Code, Chapter 15, Subchapter Q [~~O~~]. The program described in this chapter shall be known as the Water Infrastructure Fund. Unless in conflict with the provisions of this chapter, the provisions of Chapter 363, Subchapter A of this title (relating to the General Provisions of Financial Assistance Programs) shall apply to applications for assistance from the Water Infrastructure Fund.

§382.3. Use of Funds.

(a) (No change.)

(b) The board may make funding available under subsection (a) of this section only for implementation of projects which are:

(1) recommended in water management strategies in a board-approved regional water plan adopted pursuant to Texas Water Code, §16.053 or in the state water plan adopted pursuant to Texas Water Code, §16.051; or

(2) designed to develop existing sources of water consistent with sources and supplies listed in the board-approved regional water plan adopted pursuant to Texas Water Code, §16.053 or in the state water plan adopted pursuant to Texas Water Code, §16.051, provided that the fund may not be used to maintain a system or to develop a retail distribution system.

[~~(c) Funding under subsection (a)(2) of this section may not exceed 10% of the amount of financial assistance budgeted by the board to be made available from the fund in a fiscal year.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505265
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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SUBCHAPTER B. APPLICATION PROCEDURES

31 TAC §382.22

The amendments are proposed under the authority of the Texas Water Code §6.101, which provide the Texas Water Development Board with the authority to adopt rules necessary to carry out the powers and duties in the Texas Water Code and other laws of the State, and Texas Water Code §15.977 which requires the Board to adopt rules relating to the Water Infrastructure Fund.

Cross reference to statute: Water Code, Chapter 15, Subchapter Q.

§382.22. Application for Assistance.

(a) A political subdivision shall submit an application for financial assistance in writing.

(b) The following information is required on all applications to the board for financial assistance.

(1) General, fiscal and legal information required includes:

(A) - (K) (No change.)

(L) a notarized affidavit from the authorized representative stating that:

(i) for a political subdivision, the decision to request financial assistance from the board was made in a public meeting held in accordance with the Open Meetings Act (Government Code, Chapter 551);

(ii) the information submitted in the application is true and correct according to the best knowledge and belief of the representative;

(iii) the applicant has no litigation or other proceedings pending or threatened against the applicant that would materially adversely affect the financial condition of the applicant or the ability of the applicant to issue debt; [~~and~~]

(iv) the applicant has no pending, threatened, or outstanding judgments, orders, fines, penalties, taxes, assessment or other enforcement or compliance issue of any kind or nature by EPA, the Texas Commission on Environmental Quality, Texas Comptroller, Texas Secretary of State, or any other federal, state or local government, except for such actions identified in the affidavit; and

(v) [~~(iv)~~] the applicant will comply with all applicable federal laws, rules, and regulations as well as the laws of this state and the rules and regulations of the board.

(M) (No change.)

(2) - (5) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505266
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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CHAPTER 384. RURAL WATER ASSISTANCE FUND

The Texas Water Development Board (the board) proposes amendments to 31 TAC §384.1 and §384.22(b)(1)(L) concerning the Rural Water Assistance Fund. The board has reviewed 31 TAC Chapter 384 pursuant to Texas Government Code §2001.039. As a result of this review, the board proposes to amend §384.1 in order to be consistent with recent statutory amendments affecting and other board rules and proposes to §384.22 to align the requirement therein with other board programs.

The board proposes an amendment to §384.1, Scope of Chapter, to change the Subchapter of Chapter 15 of the Texas Water Code under which the Rural Water Assistance Fund is established, from Subchapter P to Subchapter R. This proposed amendment is made in order for the rule to be consistent with a statutory amendment made by the 78th Legislature.

Current §384.22(b)(1)(L)(iii) requires that the applicant submit an affidavit from its authorized representative that states that there is no pending or threatened litigation against the applicant that would materially adversely affect the financial condition of the applicant or to issue the debt. The board proposes amending this subsection by adding the requirement that the affidavit that either there is no pending or threatened judgments, orders, or fines from the Texas Commission on Environmental Quality or any other federal, state, or local government, or to identify any such judgments, orders, or fines. The reason that the board proposes this amendment is that the board currently requires this information as part of its Drinking Water State Revolving Fund Program and that by including this requirement in this program, the board develops consistency between its program requirements. Also, the board believes that as a state agency it should be aware of incidents of non-compliance by the applicant with the other arms of government prior to approving financial assistance to an applicant.

James LeBas, Chief Financial Officer, has determined that, for the first five-year period the amendments are in effect, there will not be fiscal implications on state and local government as a result of enforcement and administration of the amended sections. As a financial assistance program, no local government is required to apply for assistance. If a local government does apply, it is anticipated that the additional information requested will not have a fiscal impact on the applicant.

Mr. LeBas has also determined that, for the first five years the amendments, as proposed, are in effect the public benefit anticipated as a result of enforcing the proposed amendments will be greater consistency between the requirements of board programs resulting in greater efficiency in administering these programs. Mr. LeBas has determined there will not be economic costs to small businesses or individuals required to comply with the amendments as proposed because the provisions apply only to political subdivisions applying for board assistance.

Comments on the proposal will be accepted for 30 days following publication and may be submitted to Jonathan Steinberg, Attorney, General Counsel Office, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, by e-mail to jonathan.steinberg@twdb.state.tx.us or by fax at (512) 463-5580.

SUBCHAPTER A. INTRODUCTORY PROVISIONS

31 TAC §384.1

The amendments are proposed under the authority of the Texas Water Code §6.101 and §15.995 which authorize the board to publish rules to carry out its duties provided in the Water Code and for this program in particular.

Cross reference to statute: Water Code, Chapter 15, Subchapter R.

§384.1. Scope of Chapter.

This chapter shall govern applications for financial assistance from the Rural Water Assistance Fund, established by the Texas Water Code, Chapter 15, Subchapter R [~~P~~]. The program described in this chapter shall be known as the Rural Water Assistance Fund. Unless in conflict with the provisions of this chapter, the provisions of Chapter 363, Subchapter A of this title (relating to the General Provisions of Financial Assistance Programs) shall apply to applications for assistance from the Rural Water Assistance Fund.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505267
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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SUBCHAPTER B. APPLICATION PROCEDURES

31 TAC §384.22

The amendments are proposed under the authority of the Texas Water Code §6.101 and §15.995 which authorize the board to publish rules to carry out its duties provided in the Water Code and for this program in particular.

Cross reference to statute: Water Code, Chapter 15, Subchapter R.

§384.22. Application for Assistance.

(a) (No change.)

(b) The following information is required on all applications to the board for financial assistance.

(1) General, fiscal and legal information required includes:

(A) - (K) (No change.)

(L) a notarized affidavit from the authorized representative stating that:

(i) - *(ii)* (No change.)

(iii) the applicant has no litigation or other proceedings pending or threatened against the applicant that would materially adversely affect the financial condition of the applicant or the ability of the applicant to issue debt; [~~and~~]

(iv) the applicant has no pending, threatened, or outstanding judgments, orders, fines, penalties, taxes, assessment or other enforcement or compliance issue of any kind or nature by EPA, the Texas Commission on Environmental Quality, Texas Comptroller, Texas Secretary of State, or any other federal, state or local government, except for such actions identified in the affidavit; and

(v) [~~(iv)~~] the applicant will comply with all applicable federal laws, rules, and regulations as well as the laws of this state and the rules and regulations of the board.

(M) (No change.)

(2) - (5) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505268
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Proposed date of adoption: January 19, 2006
For further information, please call: (512) 475-2052

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 3. TEXAS YOUTH COMMISSION

CHAPTER 85. ADMISSION, PLACEMENT, AND PROGRAM COMPLETION

SUBCHAPTER C. MOVEMENT WITHOUT PROGRAM COMPLETION

37 TAC §85.41

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Youth Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Youth Commission (the commission) proposes the repeal of §85.41, concerning Maximum Length of Stay for Other

Than Type A Violent and Sentenced Offenders. The repeal of the section will allow for a significantly revised rule to be published in its place. The revised rule can be found in this issue of the *Texas Register*.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the repeal is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the repeal.

Neil Nichols, General Counsel, has determined that for each year of the first five years the repeal is in effect the public benefit anticipated as a result of enforcing the section will be the publication of an updated rule to replace this repeal. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the repeal as proposed. No private real property rights are affected by adoption of this repeal.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or e-mail to deanna.lloyd@tyc.state.tx.us.

The repeal is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its function.

The proposed repeal affects the Human Resources Code, §61.034.

§85.41. Maximum Length of Stay for Other Than Type A Violent and Sentenced Offenders.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505327
Dwight Harris
Executive Director
Texas Youth Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 424-6301

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37 TAC §85.41

The Texas Youth Commission (the commission) proposes new §85.41, concerning Maximum Length of Stay. The new section will only allow general offender youth who have completed their minimum length of stay, but have not completed the Resocialization program within their minimum length of stay to be released on parole under certain provisions. The length of time such youth must complete in high restriction to be eligible for release is now calculated based on a certain number of months in addition to (as opposed to elapsed since) completion of the minimum length of stay plus any disciplinary extensions. Furthermore, the timeframe for which a youth must be free of Category 1 rule violation(s) to be eligible for release has changed from 90 days to 30 days prior to the Special Services Committee exit review as well as releasing an eligible youth to parole was reduced from 45 days after the exit review to 30 days, and the exit review must be conducted within 14 calendar days after the youth meets release criteria.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Neil Nichols, General Counsel, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be efficient use of agency's resources. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed. No private real property rights are affected by adoption of this rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or e-mail to deanna.lloyd@tyc.state.tx.us.

The new section is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The proposed rule affects the Human Resources Code, §61.034.

§85.41. Maximum Length of Stay.

(a) Purpose. The Resocialization program is designed for youth who reasonably apply themselves to complete the program within their assigned minimum length of stay. There are, however, a small number of resistant youth who do not complete the Resocialization program within their minimum length of stay. When the length of institutional stay for these youth becomes disproportionate relative to the severity of their committing offense and level of risk to the community, provision must be made to cut short their Resocialization program in the institution and plan for their supervision and services on parole.

(b) Applicability.

(1) This rule only applies to general offenders whose assignment is to a high restriction placement.

(2) This rule does not apply to:

(A) youth who are unable to progress further in the agency's rehabilitation program because of mental illness or mental retardation and who have completed their minimum lengths of stay, see §87.79 of this title regarding such youth;

(B) any other movement without program completion or general offenders who have completed program requirements;

(C) priority 1 youth who are eligible for admission to specialized treatment programs. See §85.51 of this title for an explanation of specialized treatment for priority 1 youth; or

(D) general offenders whose placement is in the Aggression Management Program (AMP) or assigned to a Behavior Management Program (BMP).

(c) Explanation of Terms Used.

(1) Exit review/interview--means a review of documentation to determine whether the youth meets the requirements of this rule for release under parole supervision. In TYC high restriction facilities the exit review is conducted by the Special Services Committee (as de-

fined in paragraph (4) of this subsection) and in contract care programs it is conducted by the quality assurance supervisor.

(2) General Offender--means a youth who is classified as a general offender as defined in §85.23 of this title and has never been classified as a sentenced or Type A violent offender.

(3) Minimum Length of Stay--means the initial assigned minimum length of stay for the youth's classification, see §85.25 of this title for minimum length of stay requirements. For youth who are returned to a high restriction facility with no minimum length of stay, the admission date will be treated as the date the youth has completed the minimum length of stay under this rule.

(4) Special Services Committee (SSC)--the SSC is a standing committee that consists of at least five (5) members and must include:

(A) Director of Clinical Services (DOCS), Chairperson;

(B) Program Administrator (1 to 3); and

(C) Principal.

(d) Criteria for Release to TYC Parole. General offenders who have completed their minimum length of stay, but have not earned Phase 4 on all three components of Resocialization, see §87.3 of this title for Resocialization phase requirements, will be released to TYC parole (home or home substitute) when the following requirements are met:

(1) no confirmed Category I rule violations through a due process hearing within 30 days prior to the SSC exit review;

(2) completion of four (4) months in addition to the minimum length of stay, and any assigned disciplinary lengths of stay and currently on, at a minimum, Resocialization Phase A3, B3, C3; or

(3) completion of eight (8) months in addition to the minimum length of stay, and any assigned disciplinary lengths of stay and currently on, at a minimum, Resocialization Phase A2, B2, C2; or

(4) completion of 12 months in addition to the minimum length of stay, and any assigned disciplinary lengths of stay and currently on, at a minimum, Resocialization Phase A1, B1, C1.

(e) Loss of Release Eligibility. Eligibility for release is lost when a youth commits a Category 1 rule violation as confirmed through a due process hearing after the exit review. A youth who loses release eligibility will not be eligible for release until such time as the youth meets release criteria as set forth in subsection (d) of this section and a subsequent SSC exit review confirms release eligibility.

(f) Timing of Exit Review and Release Date.

(1) An exit review is conducted within 14 calendar days after the youth meets criteria for release to TYC parole under this rule.

(2) Youth who meet release criteria to TYC parole under this rule must be release within 30 calendar days of the exit review, unless an extension has been granted beyond the 30 calendar days. Upon the approval by the appropriate director of juvenile corrections, additional time may be granted beyond the 30 calendar days, but not to exceed 60 calendar days from the exit review, to address placement concerns.

(g) Notification. TYC will notify the committing juvenile judge, the prosecuting attorney, parole officer, and the county chief juvenile probation officer in the county to which the youth is being moved no later than ten (10) calendar days prior to the release.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505326
Dwight Harris
Executive Director
Texas Youth Commission
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 424-6301

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CHAPTER 91. PROGRAM SERVICES
SUBCHAPTER D. HEALTH CARE SERVICES

37 TAC §91.99

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Youth Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Youth Commission (the commission) proposes the repeal of §91.99, concerning Medical Admissions for Al Price State Juvenile Correctional Facility. The repeal reflects the commission's determination that due to the small number of youth with chronic illnesses requiring frequent medical care in the commission's custody, the operation of a specialized dorm to house such youth is no longer necessary. Such youth will continue to receive necessary medical care in accordance with rules established by the commission which govern the provision of medical care.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Neil Nichols, General Counsel, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be the efficient use of the commissions resources. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed. No private real property rights are affected by adoption of this rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or email to deanna.lloyd@tyc.state.tx.us.

The repeal is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its function.

The proposed rule affects the Human Resources Code, §61.034.

§91.99. Medical Admissions for Al Price State Juvenile Correctional Facility.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Dwight Harris
Executive Director
Texas Youth Commission
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For further information, please call: (512) 424-6301

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CHAPTER 95. YOUTH DISCIPLINE SUBCHAPTER A. DISCIPLINARY PRACTICES

37 TAC §95.21

The Texas Youth Commission (the commission) proposes an amendment to §95.21, concerning Disciplinary Practices. The amendment to the section will allow youth to be released from the Aggression Management Program (AMP) to parole when youth complete AMP requirements and meet release criteria pursuant to the new §85.41, which is proposed in this issue of the *Texas Register*. If such youth complete Stage 5 but do not meet release criteria pursuant to §85.41, youth will be release from AMP and placement will be determined by the Centralized Placement Unit.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Neil Nichols, General Counsel, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be efficient use of agency's resources and timely parole release for eligible youth. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed. No private real property rights are affected by adoption of this rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or email to deanna.lloyd@tyc.state.tx.us.

The amendment is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The proposed rule affects the Human Resources Code, §61.034.

§95.21. Aggression Management Program.

(a) - (l) (No change.)

(m) Program Completion and/or Release.

(1) (No change.)

(2) Youth who complete Stage 5 and meet the release criteria pursuant to §85.41 of this title (relating to Maximum Length of Stay) will be released from AMP to TYC parole. [~~Youth will not be released to the referring facility. The youth's release placement shall be determined by the CPU placement procedures.~~]

(3) Youth who complete Stage 5 and do not meet criteria pursuant to §85.41 of this title shall be released from AMP and placement will be determined by the Centralized Placement Unit (CPU) placement procedures. The youth's placement shall not be at the referring facility.

(4) [~~(3)~~] If transportation is not available to the assigned facility upon the completion of Stage 5, the youth will be transferred to MCSJCF's general population.

(n) - (o) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Dwight Harris
Executive Director
Texas Youth Commission
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For further information, please call: (512) 424-6301

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PART 13. TEXAS COMMISSION ON FIRE PROTECTION

CHAPTER 421. STANDARDS FOR CERTIFICATION

37 TAC §421.5

The Texas Commission on Fire Protection (TCFP) proposes an amendment to §421.5, concerning definitions, in Chapter 421, entitled Standards for Certification. The purpose of the proposed amendment is to bring definitions concerning instructors into alignment with new Chapter 425, recently adopted to be effective March 1, 2006.

The proposed amendment: 1) deletes the existing definition for "Coordinator" and renames the designation of "Training Officer" to "Chief Training Officer" to clarify that this is the title that the commission will recognize as the individual responsible for coordinating the activities of a training facility; 2) modifies the definition of "Lead Instructor" to clarify that this is the title that the commission will recognize as the individual qualified as an instructor to deliver fire protection training; 3) adds a definition for "Non-Self-Serving Affidavit"; 4) in the definition for "Years of Experience," adds to the requirements for fire instructor courses only, the following options: holding certification from the Texas Department of State Health Services (DSHS) or the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) and documentation of at least three years of experience as a volunteer in the fire service; and deletes obsolete documentation requirements for members of volunteer fire service organizations from another jurisdiction.

The TCFP has determined the amendment to be in compliance with Texas Government Code, §419.022(b) and §419.026(a).

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendment is in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed amendment is in effect, the public benefit anticipated as a result of enforcing the amendment will be greater clarity regarding instructor certification requirements and commission designations for training facility personnel. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendment.

Comments on the proposal may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and Texas Government Code, §419.028, which provides the TCFP with the authority to the issue or revoke certification for a training facility or fire protection personnel instructors.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§421.5. Definitions.

The following words and terms, when used in this standards manual, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (7) (No change.)

(8) Chief Training Officer--The individual, by whatever title he or she may be called, who coordinates the activities of a certified training facility.

(9) [~~(8)~~] Class hour--Defined as not less than 50 minutes of instruction, also defined as a contact hour; a standard for certification of fire protection personnel.

(10) [~~(9)~~] Code--The official legislation creating the commission.

(11) [~~(10)~~] College credits--Credits earned for studies satisfactorily completed at a regionally accredited institution of higher education and including National Fire Academy (NFA) open learning program colleges, or courses recommended for college credit by the American Council on Education (ACE) or delivered through the National Emergency Training Center (both EMI and NFA) programs. A course of study satisfactorily completed and identified on an official transcript from a college or in the ACE National Guide that is primarily related to Fire Service, Emergency Medicine, Emergency Management, or Public Administration is defined as applicable for Fire Science college credit, and is acceptable for higher levels of certification.

(12) [~~(11)~~] Commission--Texas Commission on Fire Protection.

(13) [~~(12)~~] Commission-recognized training--A curriculum or training program which carries written approval from the commission, or credit hours that appear on an official transcript from an accredited college or university, or any fire service training received from a nationally recognized source, i.e., the National Fire Academy.

(14) [~~(13)~~] Compensation--Compensation is to include wages, salaries, and "per call" payments (for attending drills, meetings or answering emergencies).

[~~(14) Coordinator--The official responsible for a commission approved training curriculum, training facility, and/or school (other than fire department) by whatever title he/she may be called.~~]

(15) - (26) (No change.)

(27) Lead instructor--An individual qualified as an instructor to deliver [~~charged with the responsibility of conducting a~~] fire protection training [~~school under the provision of the Code~~].

(28) - (29) (No change.)

(30) Non-self-serving affidavit--A sworn document executed by someone other than the individual seeking certification.

(31) [~~(30)~~] Participating volunteer fire fighter--An individual who voluntarily seeks certification and regulation by the commission under the Government Code, Chapter 419, Subchapter D.

(32) [~~(31)~~] Participating volunteer fire service organization--A fire department that voluntarily seeks regulation by the commission under the Government Code, Chapter 419, Subchapter D.

(33) [~~(32)~~] Part-time fire protection employee--An individual who is appointed as a part-time fire protection employee and who receives compensation, including benefits and reimbursement for expenses. A part-time fire protection employee is not full-time as defined in this section.

(34) [~~(33)~~] Personal alert safety system (PASS)--Devices that are certified as being compliant with NFPA 1982, and that automatically activates an alarm signal (which can also be manually activated) to alert and assist others in locating a fire fighter or emergency services person who is in danger.

(35) [~~(34)~~] Political subdivision--A political subdivision of the State of Texas that includes, but is not limited to the following:

(A) city;

(B) county;

(C) school district;

(D) junior college district;

(E) levee improvement district;

(F) drainage district;

(G) irrigation district;

(H) water improvement district;

(I) water control and improvement district;

(J) water control and preservation district;

(K) freshwater supply district;

(L) navigation district;

(M) conservation and reclamation district;

(N) soil conservation district;

(O) communication district;

(P) public health district;

(Q) river authority;

(R) municipal utility district;

(S) transit authority;

(T) hospital district;

(U) emergency services district;

(V) rural fire prevention district; and

(W) any other governmental entity that:

(i) embraces a geographical area with a defined boundary;

(ii) exists for the purpose of discharging functions of the government; and

(iii) possesses authority for subordinate self-government through officers selected by it.

(36) [~~(35)~~] Reciprocity for IFSAC seals--Valid documentation of accreditation from the International Fire Service Accreditation Congress used for TCFP certification which must be issued from another jurisdiction and which may only be used for obtaining initial certification.

(37) [~~(36)~~] Recognition of training--A document issued by the commission stating that an individual has completed the training requirements of a specific phase level of the Basic Fire Suppression Curriculum.

(38) [~~(37)~~] School--Any school, college, university, academy, or local training program which offers fire service training and included within its meaning the combination of course curriculum, instructors, and facilities.

(39) [~~(38)~~] Structural fire protection personnel--Any person who is a permanent full-time employee of a government entity who engages in fire fighting activities involving structures and may perform other emergency activities typically associated with fire fighting activities such as rescue, emergency medical response, confined space rescue, hazardous materials response, and wildland fire fighting.

(40) [~~(39)~~] Trainee--An individual who is participating in a commission approved training program.

[~~(40) Training officer--The officer or supervisor, by whatever title he or she may be called, that is in charge of a commission certified facility.~~]

(41) - (42) (No change.)

(43) Years of experience--For purposes of higher levels of certification or fire service instructor certification:

(A) Except as provided in subparagraph (B) of this paragraph, years of experience is defined as full years of full-time, part-time or volunteer fire service while holding:

(i) - *(iii)* (No change.)

(iv) for fire service instructor certification only, a State Firemen's and Fire Marshals' Association Level II Instructor Certification, or an [~~its~~] equivalent [,] instructor certification from the Texas Department of State Health Services (DSHS) or the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE). Documentation of at least three years of experience as a volunteer in the fire service shall be in the form of a non self-serving sworn affidavit.

[(v) ~~An individual seeking equivalent certification while a member in a volunteer fire service organization from another jurisdiction under clause (iii) of this subparagraph shall provide documentation in the form of a non self-serving affidavit as an active volunteer fire fighter in one or more volunteer fire departments. Documentation shall include attendance at 40% of the drills for each year and attendance of at least 25% of the department's emergencies in a calendar year, while a member of a volunteer department.~~]

(B) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200505238
Gary L. Warren, Sr.
Executive Director
Texas Commission on Fire Protection
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For further information, please call: (512) 239-4921

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CHAPTER 423. FIRE SUPPRESSION SUBCHAPTER A. MINIMUM STANDARDS FOR STRUCTURE FIRE PROTECTION PERSONNEL CERTIFICATION

37 TAC §423.1, §423.13

The Texas Commission on Fire Protection (TCFP) proposes amendments to §423.1 and §423.13, concerning minimum standards for structure fire protection personnel and International Fire Service Accreditation Congress (IFSAC) seals, in Chapter 423, entitled Fire Suppression. The purpose of the proposed amendments is to update obsolete information.

The proposed amendments reflect a state agency name change from "The Texas Department of Health" to "State Department of Health Services."

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendments are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the amendments will be less confusion about the official name of the Texas state agency issuing medical personnel certifications. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendments.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

The amendments are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§423.1. Minimum Standards for Structure Fire Protection Personnel.

(a) (No change.)

(b) Prior to being appointed to fire suppression duties, personnel must complete a commission approved basic structure fire suppression program and successfully complete a commission recognized emergency medical course. The individual must successfully pass the commission examination pertaining to that curriculum as required by §423.3 of this title. The commission recognizes the following medical emergency training:

(1) [~~Texas~~] Department of State Health Services Emergency Medical Service Personnel certification training;

(2) - (5) (No change.)

(c) (No change.)

§423.13. International Fire Service Accreditation Congress (IFSAC) Seal.

(a) - (c) (No change.)

(d) In order for an individual to meet the medical requirements of NFPA 1001, the individual must document successful completion of medical emergency training. The commission recognizes the following medical emergency training as meeting the medical requirements of NFPA 1001:

(1) [~~Texas~~] Department of State Health Services Emergency Medical Service Personnel certification training;

(2) - (5) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gary L. Warren, Sr.
Executive Director
Texas Commission on Fire Protection
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CHAPTER 427. TRAINING FACILITY CERTIFICATION

The Texas Commission on Fire Protection (TCFP) proposes amendments to §§427.1, 427.19, 427.201, and 427.209; the repeal of §427.17 and §427.207, and new §§427.301, 427.303, 427.305, and 427.307 concerning certification requirements for on-site and distance training providers and training programs, in Chapter 427, entitled Training Facility Certification. The purpose of the proposed repeals, amendments and new rules is to re-organize the information in the chapter to make it more easily accessible.

The proposed repeal of §427.17 and §427.207 removes rules from existing Subchapter A and Subchapter B, which deal with certification requirements for training facilities, and re-organizes some of the information in new Subchapter C, which deals exclusively with training program requirements.

The proposed amendments to §427.1, Minimum Standards for Certified Training Facilities for Fire Protection Personnel delete the word "qualified" in front of "instructor" in subsection (c), to reflect that the term "qualified instructor" is being deleted in a proposed amendment to §441.3, published concurrently in this issue of the *Texas Register*; and change from 24 hours to three business days the time period within which any deviation in the approved course schedule or content must be reported to the commission.

The proposed amendment to §427.201, Minimum Standards for Distance Training Provider, changes from 24 hours to three business days the time period within which any deviation in the approved course schedule or content must be reported to the commission.

The proposed amendments to §427.19, General Information, and §427.209, General Information, delete ambiguous language regarding supervision of trainees transported to an emergency scene; and removes a reference to "qualified instructors" to reflect that this term is being deleted in a proposed amendment to §441.3, published concurrently in this issue of the *Texas Register*.

Proposed new Subchapter C, Training Programs for On-Site and Distance Training Providers, is comprised of §427.301, General Provisions for Training Programs--On-Site and Distance Training Providers, §427.303, Training Approval Process for On-Site and Distance Training Providers, §427.305, Procedures for Testing Conducted by On-Site and Distance Training Providers, and §427.307, On-Site and Distance Training Provider Staff Requirements.

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed repeals, amendments, and new rules are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed repeals, amendments, and new rules are in effect, the public benefit anticipated as a result of enforcing the repeals, amendments, and new rules will be that the certification requirements for training facilities and training programs will be clearer to those seeking that information from the commission. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendments.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

SUBCHAPTER A. ON-SITE CERTIFIED TRAINING PROVIDER

37 TAC §427.1, §427.19

The amendments are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify training facilities and training programs, under conditions that the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§427.1. Minimum Standards for Certified Training Facilities for Fire Protection Personnel.

(a) - (b) (No change.)

(c) Minimum requirements for certification as a certified on-site training facility shall include facilities, apparatus, equipment, reference materials, standard operating procedures, [~~qualified~~] instructors, and records to support a quality education and training program. The resources must provide for classroom instruction, demonstrations, and practical exercises for the trainees to develop the knowledge and skills required for fire protection personnel certification.

(d) - (f) (No change.)

(g) All training for certification must be submitted to the commission for approval at least 20 days prior to the proposed starting date of the training. Approved courses are subject to audit by commission staff any time during the approved schedule. Any deviation in the approved course schedule or content must be reported to the commission within three business days [~~24 hours~~] of the deviation. The academy coordinator will:

(1) - (3) (No change.)

(h) (No change.)

§427.19. General Information.

(a) - (b) (No change.)

(c) A certified training facility may transport trainees to the site of an actual emergency for training purposes only if the following requirements are strictly adhered to:

(1) The trainees are kept in a group under the direct supervision of [~~an ample number of qualified~~] instructors to maintain accountability and ensure their safety;

(2) - (3) (No change.)

(d) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gary L. Warren, Sr.
Executive Director
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For further information, please call: (512) 239-4921

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37 TAC §427.17

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Commission on Fire Protection or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify training facilities and training programs, under conditions that the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§427.17. Staff.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gary L. Warren, Sr.
Executive Director
Texas Commission on Fire Protection
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SUBCHAPTER B. DISTANCE TRAINING PROVIDER

37 TAC §427.201, §427.209

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify training facilities and training programs, under conditions that the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§427.201. Minimum Standards for Distance Training Provider.

(a) - (c) (No change.)

(d) All training for certification must be submitted to the commission for approval at least 20 days prior to the proposed starting date of the training. Approved courses are subject to audit by commission staff any time during the approved schedule. Any deviation in the approved course schedule or content must be reported to the commission within three business days [~~24 hours~~] of the deviation. The academy coordinator will:

(1) - (3) (No change.)

(e) - (f) (No change.)

§427.209. General Information.

(a) - (b) (No change.)

(c) A distance training provider may transport trainees to the site of an actual emergency for training purposes only if the following requirements are strictly adhered to:

(1) The trainees are kept in a group under the direct supervision of [~~an ample number of qualified~~] instructors to maintain accountability and ensure their safety;

(2) - (3) (No change.)

(d) - (f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 14, 2005.

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Gary L. Warren, Sr.
Executive Director
Texas Commission on Fire Protection
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For further information, please call: (512) 239-4921

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37 TAC §427.207

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Commission on Fire Protection or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify training facilities and training programs, under conditions that the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§427.207. Staff.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER C. TRAINING PROGRAMS FOR ON-SITE AND DISTANCE TRAINING PROVIDERS

37 TAC §§427.301, 427.303, 427.305, 427.307

The new rules are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify training facilities and training programs, under conditions that the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§427.301. General Provisions for Training Programs--On-Site and Distance Training Providers.

(a) Training programs that are intended to satisfy the requirements for fire protection personnel certification for each curriculum must meet the objectives and competencies in that curriculum.

(b) A system for evaluating the comprehension of the trainee, including periodic and comprehensive written tests, is required. If performance skills are part of the applicable curriculum, performance testing shall be done in accordance with §427.305 of this title.

(c) The training facility must maintain records (electronic or paper) of skills testing on each examinee. The records must reflect the results of the evaluation of randomly chosen skills, the dates that the skill evaluations took place, and the names of the field examiners who conducted the evaluations.

§427.303. Training Approval Process for On-Site and Distance Training Providers.

(a) When seeking training approvals, a training provider shall certify that it has provided the resources described in §427.1(f) of this title.

(b) All training for certification must be approved by the commission. A training provider must submit to the commission a completed Training Prior Approval Form, a schedule of periodic, final, and skills tests, and a class schedule at least 20 days prior to the proposed starting date of the training.

(c) The provider of training will receive from the commission the following documents.

(1) A Notice of Course Approval. This document will serve as notification that the course has been approved by the commission and will contain the approval number assigned by the commission and the course I.D. number.

(2) An Application for Testing Form. See §439.5(b) of this title.

(3) A Certificate of Completion Form. This document must be completed by the training provider and issued to each student when the student has successfully completed the applicable curriculum.

(d) Approved courses are subject to audit by commission staff at any time during the approved schedule. Any deviation in the approved course schedule, content, field examiners, or the substitution of one instructor for another (this does not apply to the addition of an instructor to the roster of instructors already approved by the commission) must be reported to the commission within three business days of the deviation.

§427.305. Procedures for Testing Conducted by On-Site and Distance Training Providers.

(a) The requirements and provisions in this section apply to procedures for periodic, final, and skills testing conducted by training providers during and at the end of a training program. For procedures regarding state examinations for certification (commission examinations that occur after a training program is completed), see Chapter 439 of this title.

(b) Periodic and comprehensive final tests shall be given by the training provider in addition to the commission examination required in Chapter 439 of this title.

(c) Periodic written tests shall be administered at the ratio of one test per 50 hours of recommended training, or portion thereof. In addition to periodic tests, a comprehensive final written test must be administered. A passing score of 70% must be achieved on all required written tests. If a course is taught in phases, one comprehensive final written test shall be administered at the completion of all phases and a passing score of 70% must be achieved.

(d) If performance skill evaluations are part of the applicable curriculum, performance testing shall be done and records kept in accordance with §427.301 of this title. This will ensure that each trainee has demonstrated an ability to competently and carefully perform all tasks and operations associated with the training, both individually and as a member of a team.

(e) Performance testing should be used to the maximum extent practical. The performance skills contained in the applicable curriculum shall be used to satisfy performance skills requirements. Each trainee shall be prepared to demonstrate any performance skill in the presence of a commission representative as required in Chapter 439 of this title.

§427.307. On-Site and Distance Training Provider Staff Requirements.

(a) The chief training officer of a training facility, as a minimum, must possess Fire Service Instructor III certification.

(b) All training instructors (except guest instructors) must possess fire instructor certification. The instructor(s) must be certified in the applicable discipline or be approved by the commission to instruct in the applicable subject.

(c) The lead instructor, as a minimum, shall possess a Fire Service Instructor II certification and must be certified by the commission in the applicable discipline.

(d) Guest instructors are not required to be certified as instructors. A guest instructor is defined as an individual with special knowledge, skill, and expertise in a specific subject area who has the ability to enhance the effectiveness of the training. Guest instructors shall teach under the endorsement of the lead instructor.

(e) In order to teach fire officer certification courses, an individual who does not meet the requirements of subsection (a) or (c) of this section, shall possess a minimum of a bachelor's degree in management or its equivalent.

(f) In order to teach an instructor certification training course for Fire Service Instructor I, an individual must hold one of the following three qualifications:

(1) Hold a Fire Service Instructor II or higher; or

(2) A Bachelor's degree with the following:

(A) As a minimum, a minor in education; and

(B) Three years of teaching experience in a fire department, department of a state agency, educational institution, or political subdivision of the state, during which time the individual taught a minimum of 200 class hours; or

(3) An Associate's degree with the following:

(A) twelve semester hours of education instructional courses, and

(B) five years of teaching experience in a fire department, department of a state agency, educational institution, or political subdivision of the state, during which time the individual taught a minimum of 400 class hours.

(g) In order to teach an instructor certification training course for Fire Service Instructor II or III, an individual must hold one of the following three qualifications:

(1) Hold a Fire Service Instructor III; or

(2) A Bachelor's degree with the following:

(A) As a minimum, a minor in education; and

(B) Three years of teaching experience in a fire department, department of a state agency, educational institution, or political subdivision of the state, during which time the individual taught a minimum of 200 class hours; or

(3) An Associate's degree with the following:

(A) twelve semester hours of education instructional courses; and

(B) five years of teaching experience in a fire department, department of a state agency, educational institution, or political subdivision of the state, during which time the individual taught a minimum of 400 class hours.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 429. MINIMUM STANDARDS FOR FIRE INSPECTORS

The Texas Commission on Fire Protection (TCFP) proposes amendments to §§429.3, 429.11, and 429.211, concerning minimum standards for basic fire inspector certification and International Fire Service Accreditation Congress (IFSAC) seals, in Chapter 429, entitled Minimum Standards for Fire Inspectors. The purpose of the proposed amendments is to update obsolete information and make a grammatical correction.

The proposed amendment to §429.3 removes obsolete language pertaining to curriculum requirements for fire inspector certification that were in effect prior to January 1, 2005 and are no longer relevant.

The proposed amendments to §429.11 and §429.211 correct the title "Plans Examiner" to "Plan Examiner."

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendments are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the amendments will be greater clarity regarding the curriculum requirements for fire inspector certification. There are no additional costs of compliance

for small or large businesses or individuals that are required to comply with the proposed amendments.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

SUBCHAPTER A. MINIMUM STANDARDS FOR FIRE INSPECTOR CERTIFICATION BASED ON REQUIREMENTS IN EFFECT PRIOR TO JANUARY 1, 2005

37 TAC §429.3, §429.11

The amendments are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§429.3. Minimum Standards for Basic Fire Inspector Certification.

(a) In order to be certified by the commission as a Basic Fire Inspector an individual must complete a commission approved Basic Fire Inspector Curriculum dated prior to January 1, 2005 [~~fire inspection training program~~] and successfully pass the commission examination as specified in Chapter 439 of this title (relating to Examinations for Certification). [~~An approved basic fire inspection training program shall consist of one or any combination of the following:~~]

[~~(1) completion of the commission approved Basic Fire Inspector Curriculum, dated prior to January 1, 2005; or~~]

[~~(2) successful completion of an out-of-state training program which has been submitted to the commission for evaluation and found to meet the minimum requirements as listed in the commission approved Basic Fire Inspector Curriculum as specified in Chapter 4 of the commission's Certification Curriculum Manual; or~~]

[~~(3) successful completion of the following college courses:~~]

[~~(A) Fire Protection Systems, three semester hours;~~]

[~~(B) Fire Prevention, three semester hours; or Fire Prevention Codes and Investigations, three semester hours;~~]

[~~(C) Building Code, three semester hours;~~]

[~~(D) Building Construction, three semester hours;~~]

[~~(E) Hazardous Materials, three semester hours; Total semester hours, 15*. *NOTE: Building Code and Building Construction may be combined into a single three semester hour class. If this is the case, the total semester hours may be reduced to 12. Hazardous Materials I or II may be used to satisfy the requirements of Hazardous Materials; or~~]

[~~(4) successful completion of a National Fire Academy program for fire inspection. The program must include the basic course, Fire Inspection Principles I, and two of the following courses or their predecessor:~~]

[~~(A) Fire Prevention Specialist II; or~~]

[~~(B) Plans Review for Inspectors; or~~]

[~~(C) Code Management: A Systems Approach; or~~]

[~~(D) Management of Fire Prevention Programs; or~~]

[~~(E) Strategic Analysis of Fire Prevention Programs.~~]

[~~(b) National Fire Academy courses that replace a course discontinued by the National Fire Academy may be used towards requirements for certification in place of the discontinued course.~~]

(b) [~~(c)~~] A person who holds or is eligible to hold a certificate upon employment as a part-time fire inspector may be certified as a fire inspector, of the same level of certification, without meeting the applicable examination requirements.

§429.11. International Fire Service Accreditation Congress (IFSAC) Seal.

(a) (No change.)

(b) Individuals who hold commission Fire Inspector certification prior to January 1, 2005, may apply to test for Plan [~~Plans~~] Examiner I. Upon successful completion of the examination an IFSAC seal for Plan [~~Plans~~] Examiner I may be granted by making application to the commission for the IFSAC seal and paying the applicable fee.

(c) - (e) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER B. MINIMUM STANDARDS FOR FIRE INSPECTOR CERTIFICATION

37 TAC §429.211

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§429.211. International Fire Service Accreditation Congress (IFSAC) Seal--New Track.

(a) (No change.)

(b) Individuals who hold commission Fire Inspector certification prior to January 1, 2005, may apply to test for Plan [~~Plans~~] Examiner I. Upon successful completion of the examination an IFSAC seal for Plan [~~Plans~~] Examiner I may be granted by making application to the commission for the IFSAC seal and paying the applicable fee.

(c) (No change.)

(d) Individuals who pass the applicable state examination prior to January 1, 2005, may apply to test for Plan [~~Plans~~] Examiner I. Upon successful completion of the examination an IFSAC seal for Plan [~~Plans~~] Examiner I may be granted by making application to the commission for the IFSAC seal and paying the applicable fee.

(e) Individuals who pass the applicable section of the state examination on or after January 1, 2005, may be granted IFSAC seal(s) for Inspector I, Inspector II, and/or Plan [~~Plans~~] Examiner I by making application to the commission for the IFSAC seal(s) and paying the applicable fees, provided they meet the following provisions:

(1) (No change.)

(2) To receive the IFSAC Inspector II seal, the individual must:

(A) (No change.)

(B) document possession of an IFSAC Inspector I seal [~~or a passing score on the corresponding section of a commission examination~~]; and

(C) (No change.)

(3) To receive the IFSAC Plan [~~Plans~~] Examiner I seal, the individual must:

(A) complete the Plan [~~Plans~~] Examiner I section of a commission-approved course; and

(B) pass the Plan [~~Plans~~] Examiner I section of a commission examination.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 435. FIRE FIGHTER SAFETY

37 TAC §435.5, §435.21

The Texas Commission on Fire Protection (TCFP) proposes an amendment to §435.5 entitled Fire Service Joint Labor Management Wellness-Fitness Initiative, in Chapter 435, entitled Fire Fighter Safety and proposes new §435.21, Fire Service Joint Labor Management Wellness-Fitness Initiative. The purpose of the proposed amendment is to endorse the Fire Service Joint Labor Management Wellness-Fitness Initiative established by International Association of Fire Fighters (IAFF) and the International Association of Fire Chiefs (IAFC). The IAFF/IAFC initiative recognizes the physical and emotional stresses associated with the job that fire fighters perform and recommends specific actions that would mitigate or lessen the impact of those stresses.

The commission established an ad-hoc committee on Fire Fighter Wellness and Fitness. The committee was charged with reviewing the current state of wellness and fitness of the fire service in Texas. They were to make recommendations to the commission regarding the promulgation of rules concerning the standards for fire fighter physicals, health, safety, and wellness.

The committee sent surveys to more than 600 Texas fire service agencies and received a response from 111 fire departments. Based upon the survey results and other information gathered, the committee made recommendations to the commission concerning possible interventions regarding regulated fire service agencies.

The proposed amendment to §435.5 adds the IAFF/IAFC Fire Service Joint Labor Management Wellness-Fitness Initiative to the list of resources that the commission recommends employing entities use as a guide. Proposed new §435.21, Fire Service Joint Labor Management Wellness-Fitness Initiative, sets out provisions regarding the initiative, including that employing entities shall assess the wellness and fitness needs of their personnel; that they shall develop, maintain, and make available for commission inspection a standard operating procedure; and that the approach an employing entity takes regarding personnel fitness needs shall be based on the local assessment of resources.

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendment and new rule are in effect any fiscal impact on state and local governments will be based upon their assessment of their needs.

Mr. Soteriou has also determined that for each of the first five years the proposed amendment and new rule are in effect, the public benefit anticipated as a result of enforcing the amendment and new rule could be a reduction in work-related injuries and illnesses among fire fighters, resulting in a more efficient and effective fire service. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendment.

Comments on the proposal may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

The amendment and new rule are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022(a)(5) are affected by this rulemaking.

§435.5. Commission Recommendations.

The commission recommends that all employing entities use as a guide[~~, for all fire protection operations,~~] the following publications:

(1) NFPA 1403 "Live Fire Training Evolutions";

(2) NFPA 1500 "Fire Department Occupational Safety and Health Program;[.]"

(3) IAFF/IAFC - "Fire Service Joint Labor Management Wellness-Fitness Initiative."

§435.21. Fire Service Joint Labor Management Wellness-Fitness Initiative.

(a) A fire department shall assess the wellness and fitness needs of the personnel in the department.

(b) A fire department shall develop and maintain a standard operating procedure to address those needs.

(c) The approach to the fitness needs of the department shall be based on the local assessment and local resources.

(d) The standard operating procedure shall be made available to the commission for inspection.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 439. EXAMINATIONS FOR CERTIFICATION

The Texas Commission on Fire Protection (TCFP) proposes the repeal of §§439.1, 439.3, 439.5, 439.7, 439.9, 439.11, 439.13, 439.15, 439.17, 439.201, 439.203, and 439.205; and new §§439.1, 439.3, 439.5, 439.7, 439.9, 439.11, 439.13, 439.15, 439.17, 439.19, 439.201, 439.203, and 439.205, concerning general requirements and procedures regarding state administered examinations, performance skill evaluations, testing for proof of proficiency, and grading, in Chapter 439, entitled Examinations for Certification.

The purpose of the proposed repeals and new rules is to re-organize the information in the chapter to make it more easily accessible.

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed repeals and new rules are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed repeals and new rules are in effect, the public benefit anticipated as a result of enforcing the repeals and new rules will be that the procedures and requirements regarding commission examinations for certification will be clearer to those seeking that information from the commission. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed repeals and new rules.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

SUBCHAPTER A. EXAMINATIONS FOR ON-SITE DELIVERY TRAINING

37 TAC §§439.1, 439.3, 439.5, 439.7, 439.9, 439.11, 439.13, 439.15, 439.17

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Commission on Fire Protection or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeals are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum educational, training, physical, and mental standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§439.1. Requirements--General.
§439.3. Definitions.
§439.5. Procedures.
§439.7. Eligibility.
§439.9. Grading.
§439.11. Performance Skill Evaluation.
§439.13. Testing for Proof of Proficiency.
§439.15. Testing for Certification Status.
§439.17. Number of Test Questions.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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37 TAC §§439.1, 439.3, 439.5, 439.7, 439.9, 439.11, 439.13, 439.15, 439.17, 439.19

The new rules are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum educational, training, physical, and mental standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§439.1. Requirements--General.

(a) The administration of examinations for certification, including performance skill evaluations, shall be conducted in compliance with commission and International Fire Service Accreditation Congress (IFSAC) regulations. It is incumbent upon commission staff, committee members, training officers and field examiners to maintain the integrity of any state examination (or portion thereof) for which they are responsible.

(b) Exams will be based on curricula as currently adopted in the commission's Certification Curriculum Manual. The state test can consist of only a written test or it can consist of a test that contains both a written portion and a performance skills portion. If the training program is conducted in the phase format, the examination will be based on the curriculum in effect at the time of the examination.

(c) If performance skills are required as part of a certification examination, the entity applying for the certification examination shall be responsible for providing the required number of approved field examiners. The number of field examiners shall be determined by the commission.

(d) Commission examinations that receive a passing grade shall expire two years from the date of the examination.

(e) The commission shall prescribe the content of any certification examination that tests the knowledge and/or skill of the examinee concerning the discipline addressed by the examination.

(1) An examination based on Chapter 1, "Basic Fire Suppression Curriculum" as identified in the Certification Curriculum Manual may consist of four sections: Fire Fighter I, Fire Fighter II, First Responder Awareness, and First Responder Operations.

(2) An examination based on Chapter 4, "Basic Fire Inspector Curriculum" as identified in the Certification Curriculum Manual may consist of three sections: Inspector I, Inspector II, and Plan Examiner I.

(3) All other state examinations consist of only one section.

(f) An individual who fails to pass a commission written examination for state certification will be given one additional opportunity to pass the examination or section thereof. This opportunity must be exercised within 180 days after the date of the first failure. An individual who passes the applicable state certification examination but fails to pass a section thereof for an IFSAC seal(s) will be given one additional opportunity to pass the section thereof. This opportunity must be exercised within two years after the date of the first attempt. An examinee who fails to pass the examination within the required time may not sit for the same examination again until the examinee has re-qualified by repeating the curriculum applicable to that examination.

(g) An examinee who fails a state performance skill evaluation may be allowed a retest at a time and place to be determined by the lead examiner. If the candidate fails the retest, remedial training conducted by a certified instructor who is approved to teach in that specific subject area is required for a second retest. Remedial training must be of a duration no less than the recommended curriculum instructional hours for the section in which the failed skill(s) is reflected. An examinee being retested on a performance skill must be retested on any skill, randomly selected by the lead examiner, from the same subject area as the performance skill objective that was failed. If the examinee fails the final retest as part of a state performance skill evaluation, the examinee must requalify by repeating the entire curriculum applicable to the examination.

§439.3. Definitions.

The following words and terms, when used in this chapter, have the following definitions unless the context clearly indicates otherwise.

(1) Certificate of Completion--A signed statement certifying that an individual has successfully completed a commission-approved certification curriculum or phase program for a particular discipline, including having been evaluated by field examiners on performance skills identified by the commission. The certificate of completion will be on a form provided by the commission and is to be completed and signed by the provider of training and issued to the individual upon successful completion of the training. The certificate of completion must, as a minimum, identify the provider of training, the course I.D. number, the course approval number, date issued, curriculum name, training officer, and the name of the person completing the course. The certificate of completion qualifies an individual to take an original certification examination.

(2) Curriculum--The competencies established by the commission as a minimum requirement for certification in a particular discipline.

(3) Designee--An entity or individual approved by the standards division director to administer commission certification examinations and/or performance skills in accordance with this chapter.

(4) Eligibility--A determination of whether or not an individual has met the requirements set by the commission and would therefore be allowed to take a commission examination.

(5) Endorsement of eligibility--A signed statement testifying to the fact that an individual has met all requirements specified by the commission and is qualified to take a commission examination. An endorsement of eligibility will be issued, when appropriate, by a member of the commission staff.

(6) Examination--A state test administered by the commission which an examinee must pass as one of the requirements for certification.

(7) Examinee--An individual who has met the commission requirements and therefore qualifies to take the commission examination.

(8) Field examiner--An individual authorized to evaluate performance skills in commission-approved curricula. The field examiner must possess a Fire Instructor Certification, complete the on-line commission field examiner course, and sign an agreement to comply with the commission's testing procedures. The field examiner must be approved by the commission to instruct all subject areas identified in the curriculum that he or she will be evaluating. The field examiner will work under the supervision of a lead examiner during a commission-administered examination. The field examiner must repeat the examiner course every two years and submit a new Letter of Intent.

(9) Lead Examiner--A member of the commission staff or a designee who has been assigned by the commission to administer a commission examination.

(10) Letter of Intent--A statement, signed by an individual applying to the commission for field examiner status, that he or she is familiar with the commission's examination procedures, and agrees to abide by the policies and guidelines as set out in Chapter 439 of this title.

§439.5. Procedures.

(a) Procedures for conducting written and/or performance examinations are determined by the commission.

(b) As part of the training approval process, the designated training officer, except for a Basic Fire Suppression academy, will choose a test location and date from the list provided by the commission. The designated training officer of a Basic Fire Suppression academy may request during the training approval process to schedule the examination as soon as possible after the completion of the applicable course and at a place agreeable to the commission. The provider of training will receive from the commission an Application for Testing form with the course approval notice which will reflect the tentative date, time, and location of the examination. The provider of training must have each examinee complete the Application for Testing form and return it to the commission office no later than the third day of

instruction. The commission, upon receipt of the Application for Testing form, will confirm the time and place for the examination.

(c) All training providers are responsible for ensuring that all testing fees due to the commission are paid in a timely manner. In addition, all training providers of a Basic Fire Suppression academy that schedule through the commission an examination for less than ten (10) examinees must pay an examination fee equal to the amount that would be charged for ten (10) examinees.

(d) If the designated training officer determines that the time and/or place of the examination as set by the commission is not acceptable for good cause, he or she may request the commission to reschedule or relocate the examination providing the request is received at least 20 days prior to the original scheduled time of the examination or the new proposed time, whichever would result in the earliest notification. The commission shall give all such requests due consideration and may reschedule or relocate the examination as necessary.

(e) Each examination must be administered by a lead examiner.

(f) The lead examiner may administer the examination alone or with the assistance of field examiner(s). The field examiners shall be approved by the commission prior to the administration of the examination.

(g) The lead examiner must:

(1) ensure that the tests remain secure and that the examination is conducted under conditions warranting honest results;

(2) collect all examination materials from any examinee who is dismissed;

(3) monitor the examination while in progress;

(4) control entrance to and exit from the test site;

(5) permit no one in the room while the written test is in progress except examiners, examinees, and commission staff;

(6) assign or re-assign seating; and

(7) bar admission to or dismiss any examinee who fails to comply with any of the applicable provisions of this chapter.

(h) Examination booklets, answer sheets, scratch paper and grade roster(s) will be delivered to the lead examiner by means specified by the commission. The lead examiner must immediately notify the commission and document any errors detected in the examination materials provided.

(i) Immediately following the completion of the written examination, the lead examiner must remit to the commission all examination booklets, answer sheets and scratch paper in the return container provided by the commission.

(j) All official grading and notification must come from the commission. The commission staff must make available the preliminary test results within seven (7) business days after completion of the examination.

§439.7. Eligibility.

(a) An examination may not be taken by an individual who currently holds an active certificate from the commission in the discipline to which the examination pertains, unless required by the commission in a disciplinary matter.

(b) An individual who passes an examination and is not certified in that discipline, will not be allowed to test again until 30 days before the expiration date of the previous examination unless required by the commission in a disciplinary matter.

(c) In order to qualify for a commission examination, the examinee must:

(1) meet or exceed the minimum requirements set by the commission as a prerequisite for the specified examination;

(2) provide the lead examiner with a copy of a Certificate of Completion for the course required for the specific examination sought or an endorsement of eligibility issued by the commission;

(3) bring to the test site and display upon request some form of identification which contains the name and a photograph of the examinee;

(4) report on time to the proper location; and

(5) comply with all the written and verbal instructions of the lead examiner.

(d) No examinee shall be permitted to:

(1) violate any of the fraud provisions of this section;

(2) disrupt the examination;

(3) bring into the examination site any books, notes, or other written materials related to the content of the examination;

(4) refer to, use, or possess any such written material at the examination site;

(5) give or receive answers or communicate in any manner with another examinee during the examination;

(6) communicate at any time or in any way, the contents of an examination to another person for the purpose of assisting or preparing a person to take the examination;

(7) steal, copy, or reproduce any part of the examination;

(8) engage in any deceptive or fraudulent act either during an examination or to gain admission to it;

(9) solicit, encourage, direct, assist, or aid another person to violate any provision of this section; or

(10) bring into the examination site any electronic devices.

(e) No person shall be permitted to sit for any commission examination who has an outstanding debt owed to the commission.

§439.9. Grading.

(a) For a score to be valid and remain valid:

(1) the examinee must complete the answer sheet, or otherwise record the answers, as instructed by the lead examiner; and

(2) if performance skills are required as a part of the examination, the examinee must demonstrate performance skill objectives in a manner consistent with performance skill evaluation forms provided by the commission. The evaluation format for a particular performance skill will determine the requirements for passage of the skill. Each performance skill evaluation form will require successful completion of one of the following formats:

(A) all mandatory tasks; or

(B) an accumulation of points to obtain a passing score of at least 70%; or

(C) a combination of both (A) and (B).

(b) The minimum passing score on each written examination or section thereof as outlined in §439.1(e) of this title shall be 70%. This means that 70% of the total possible active questions must be

answered correctly. The commission may, at its discretion, invalidate any question.

(c) If the commission invalidates an examination score for any reason, it may also, at the discretion of the commission and for good cause shown, require a retest to obtain a substitute valid test score.

§439.11. Academy Administered Performance Skill Evaluation.

(a) The provider of training of a Basic Fire Suppression Fire Fighter I academy will receive from the commission with the course approval notice at least seven randomly selected performance skill objectives from Section II of the Performance Evaluation Forms that each examinee must successfully complete prior to the commission examination. The provider of training of a Basic Fire Suppression Fire Fighter II academy will receive from the commission with the course approval notice at least seven randomly selected performance skill objectives from Section III of the Performance Evaluation Forms that each examinee must successfully complete prior to the commission examination. The provider of training of a Basic Fire Suppression Fire Fighter I and Fire Fighter II combined academy will receive from the commission with the course approval notice at least seven randomly selected performance skill objectives from Section II and Section III of the Performance Evaluation Forms that each examinee must successfully complete prior to the commission examination. One of the seven randomly selected skills must be a live fire skill.

(b) The evaluation for competency to qualify for the state performance skills evaluation may occur at any time during the course of instruction but must take place after all training on the identified subject area has been completed. The number of opportunities to successfully complete particular performance skill objectives evaluated during an academy is at the discretion of the designated training officer. Retests must be conducted prior to the completion of the course. All skills must be demonstrated in the presence of a commission-approved field examiner. The instructor of a particular subject may not evaluate the performance skill related to that subject unless the instructor is an approved field examiner. At the conclusion of a course at an approved training facility, the examinee must complete the state performance skill evaluation in accordance with §439.13 of this title.

(c) During the course of instruction, the provider of training, except for a Basic Fire Suppression academy identified in subsection (a) of this section, shall test for competency all performance skills listed in the applicable curriculum. This applies only for curricula in which performance standards have been developed. Retests must be conducted prior to the completion of the course. All skills must be demonstrated before a commission-approved field examiner.

§439.13. State Administered Performance Skill Evaluation.

(a) The examinee must complete a state performance skill evaluation in accordance with subsection (b) of this section.

(b) The state performance skill evaluation must consist of at least three successfully completed performance skill objectives evaluated by field examiners under the supervision of a lead examiner after completion of an approved curriculum.

(1) The state performance skill evaluation of a Basic Fire Fighter I academy or a combined Fire Fighter I and Fire Fighter II academy must consist of one skill pertaining to self-contained breathing apparatus and at least two other skills identified as a critical skill in Section I of the Performance Evaluation Forms.

(2) Each student's performance skill evaluation routing card must show the results of the evaluations and be signed by the field examiner(s) performing the evaluation(s).

§439.15. Testing for Proof of Proficiency.

(a) An individual whose certificate has been expired for one year or longer may not renew the certificate that was previously held.

(b) The individual may obtain a new certificate in the discipline which was previously held by passing a commission proficiency examination pertaining to the discipline held. If performance skills are part of the proficiency examination, the individual may be exempted from that portion of the examination by documenting twenty hours of continuing education for each year since the expiration of the certificate for a maximum of five years. Individuals taking the exam based on the Basic Fire Suppression Curriculum do not have to show proof of medical training. The continuing education training must be done within the most recent five years and must be in subjects contained in the basic curriculum for the discipline. At least one-half of the continuing education must be hands-on performance skills. The training must be conducted as specified in Chapter 441 of this title (relating to Continuing Education).

(c) An individual or entity may petition the commission for a waiver of the examination required by this section if the person's certificate expired because of the individual or employing entity's good faith clerical error, or expired as a result of termination of the person's employment where the person has been restored to employment through a disciplinary procedure or a court action. All required renewal fees including applicable late fees and all required continuing education must be submitted before the waiver request may be considered.

(1) Applicants claiming good faith clerical error must submit a sworn statement together with any supporting documentation that evidences the applicant's good faith efforts to comply with commission renewal requirements and that failure to comply was due to circumstances beyond the control of the applicant.

(2) Applicants claiming restoration to employment as a result of a disciplinary or court action must submit a certified copy of the order restoring the applicant to employment.

§439.17. Testing for Certification Status.

(a) If an individual who has never held certification in a discipline defined in §421.5 of this title, seeks certification in that discipline, the individual shall:

(1) complete all certification requirements; and

(2) complete the examination process pertaining to that discipline. All portions of an examination must be passed before the individual is considered to have passed the examination. If it has been less than four years since an individual passed the performance skills portion of an examination pertaining to a discipline, the individual may be exempted from that portion of the examination if the individual can document twenty hours of continuing education for each year since the individual last passed the performance skills portion of an examination pertaining to the discipline. The continuing education must be in subjects contained in the curriculum for the discipline. At least one-half of the continuing education must be hands-on performance skills. The training must be conducted as specified in Chapter 441 of this title (relating to Continuing Education).

(b) If an individual completes an approved training program that has been evaluated and deemed equivalent to a certification curriculum approved by the commission, such as an out-of-state or military training program or a training program administered by the State Firemen and Fire Marshals' Association of Texas, the individual must pass a commission examination for certification status and meet any other certification requirements in order to become eligible for certification by the commission as fire protection personnel.

§439.19. Number of Test Questions.

(a) Each written examination may have two types of questions: pilot and active. Pilot questions are new questions placed on the examination for statistical purposes only. These questions do not count against an examinee if answered incorrectly.

(b) The number of questions on the written portion of the state examination will be based upon the number of recommended hours in the particular curriculum being tested. The standard is outlined below: Figure: 37 TAC §439.19(b)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gary L. Warren, Sr.
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Texas Commission on Fire Protection
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For further information, please call: (512) 239-4921

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SUBCHAPTER B. EXAMINATIONS FOR DISTANCE TRAINING

37 TAC §§439.201, 439.203, 439.205

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Commission on Fire Protection or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeals are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum educational, training, physical, and mental standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§439.201. Requirements--General.

§439.203. Procedures.

§439.205. Performance Skill Evaluation.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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37 TAC §§439.201, 439.203, 439.205

The new rules are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum educational, training, physical, and mental standards for appointment as fire protection personnel.

Texas Government Code, §419.008 and §419.022 are affected by this rulemaking.

§439.201. Requirements--General.

The examination requirements for those completing distance training shall be the same as those in Subchapter A of this chapter, except as noted in this subchapter.

§439.203. Procedures.

(a) Once distance training is completed, each individual receiving a certificate of completion must contact the commission to obtain the appropriate test application packet unless the commission has established an examination with the provider of training.

(b) To apply for a state administered commission examination, an individual who completes distance training must complete the Application for Testing form and return it to the commission with the individual's certificate of completion. The commission, upon receipt of the Application for Testing form and supporting documentation, will confirm the time and place for the examination.

§439.205. Performance Skill Evaluation.

(a) State performance skill evaluation. If a performance skill test is part of a commission examination, the examinee must complete a state performance skill evaluation as indicated in the particular standard related to the curriculum being tested or examined.

(b) Evaluation procedures. If the performance skill portion of a state exam is to be evaluated by an approved field examiner who will not observe the completion of the skill while in the immediate physical presence of the examinee, a letter of assurance from the candidate's training officer or fire chief is required stating that the fire department assures the integrity of the evaluation procedure. If the candidate is not a member of a fire department, then a certified fire instructor, fire chief, or training officer may provide a letter of assurance that meets the requirements of this subsection. The provider of distance training is required to keep a record of this assurance and provide it to the commission upon request.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 441. CONTINUING EDUCATION

37 TAC §441.3, §441.5

The Texas Commission on Fire Protection (TCFP) proposes amendments to §441.3 and §441.5, concerning continuing

education definitions and requirements, in Chapter 441, entitled Continuing Education. The purpose of the proposed amendments is to update obsolete information.

The proposed amendment to §441.3, Definitions, deletes the definition for "Qualified Instructor." It has been rendered obsolete because the commission's new instructor rules which become effective March 1, 2006 require all fire service instructors to be certified, with the exception of guest instructors who contract with training facilities (individuals with special knowledge, skill, and expertise in a specific subject area and who must teach under the endorsement of the lead instructor).

The proposed amendment to §441.5 deletes references to "qualified instructors" for the same reason as stated in the preceding paragraph of this preamble.

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendments are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the amendments will be less confusion about the terms for the different kinds of instructors staffing certified training facilities. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendments.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

The amendments are proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022(a)(5), which provides the TCFP with the authority to establish minimum standards for appointment as fire protection personnel; and §419.028, which provides the TCFP with the authority to certify persons as qualified fire protection personnel instructors under conditions which the TCFP prescribes.

Texas Government Code, §§419.008, 419.022, and 419.028 are affected by this rulemaking.

§441.3. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) (No change.)

[~~(2) Qualified instructor--An individual who may or may not be certified, but has, in either case, met as a minimum the requirements for basic instructor certification.~~]

(2) [~~(3)~~] Track A--Training intended to maintain previously learned skills as stated in the commission certification curriculum manual for the certifications held.

(3) [~~(4)~~] Track B--Fire service training or education intended to develop new skills that are not contained in the commission's certification curriculum manual for certifications held.

§441.5. Requirements.

(a) - (b) (No change.)

(c) Track A training must be conducted by a [~~qualified or~~] certified instructor. Interactive computer-based continuing education training that is supervised and verified by a certified instructor is acceptable.

(d) - (n) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 451. FIRE OFFICER

The Texas Commission on Fire Protection (TCFP) proposes amendments to §451.3 and §451.203, concerning minimum standards for Fire Officer I and II certification, in Chapter 451, entitled Fire Officer. The purpose of the proposed amendments is to add new requirements for Fire Officer I certification as required in the new National Fire Protection Association (NFPA) Standard and to reflect changes made to the instructor certification titles in the new instructor rules effective March 1, 2006.

The proposed amendment to §451.3, Minimum Standards for Fire Officer I Certification, adds the requirement that an individual must hold Fire Service Instructor I certification through the commission. The proposed amendment to §451.203, Minimum Standards for Fire Officer II Certification, changes the titles of the required instructor certifications from Intermediate Fire Service Instructor to Fire Service Instructor I; and removes other obsolete instructor certification titles.

Mr. Jake Soteriou, Director of the Fire Service Standards and Certification Division, has determined that for the first five year period the proposed amendments are in effect there will be no fiscal impact on state and local governments.

Mr. Soteriou has also determined that for each of the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the amendments will be the assurance that individuals holding fire officer certification in Texas will also have had the thorough instructor training required for instructor certification. There are no additional costs of compliance for small or large businesses or individuals that are required to comply with the proposed amendments.

Comments on the proposals may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us. Comments must be received within 30 days of publication of this proposal in the *Texas Register*.

SUBCHAPTER A. MINIMUM STANDARDS FOR FIRE OFFICER I

37 TAC §451.3

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; and Texas Government Code, §419.032(b), which provides the TCFP with the authority to establish minimum qualifications relating to certification.

Texas Government Code, §419.008 and §419.032(b) are affected by this rulemaking.

§451.3. Minimum Standards for Fire Officer I Certification.

(a) In order to be certified as a Fire Officer I an individual must:

(1) (No change.)

(2) hold Fire Service Instructor I certification through the commission; and

(A) [~~(2)~~] possess valid documentation of accreditation from the International Fire Service Accreditation Congress as Fire Fighter II and Fire Officer I; or

(B) [~~(3)~~] complete a commission approved Fire Officer I program and successfully pass the commission examination as specified in Chapter 439 of this title (relating to Examinations for Certification). An approved Fire Officer I program must consist of one of the following:

(i) [~~(A)~~] completion of a commission approved Fire Officer I Curriculum as specified in Chapter 9 of the commission's Certification Curriculum Manual;

(ii) [~~(B)~~] completion of an out-of-state training program that has been submitted to the commission for evaluation and found to be equivalent to or exceed the commission approved Fire Officer I Curriculum;

(iii) [~~(C)~~] completion of a military training program that has been submitted to the commission for evaluation and found to be equivalent or exceed the commission approved Fire Officer I Curriculum; or

(iv) [~~(D)~~] successful completion of 15 college semester hours consisting of the following courses or their equivalent:

(I) [~~(i)~~] Fire Prevention Codes and Inspections, 3 semester hours;

(II) [~~(ii)~~] Fire and Arson Investigation I or II, 3 semester hours;

(III) [~~(iii)~~] Fire Administration I, 3 semester hours;

(IV) [~~(iv)~~] Firefighting Strategies and Tactics I or II, 3 semester hours; and

(V) [~~(v)~~] Company Fire Officer, 3 semester hours.

(b) - (d) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER B. MINIMUM STANDARDS FOR FIRE OFFICER II

37 TAC §451.203

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with the authority to propose rules for the administration of its powers and duties; and Texas Government Code, §419.032(b), which provides the TCFP with the authority to establish minimum qualifications relating to certification.

Texas Government Code, §419.008 and §419.032(b) are affected by this rulemaking.

§451.203. Minimum Standards for Fire Officer II Certification.

(a) In order to be certified as a Fire Officer II an individual must:

(1) (No change.)

(2) hold Fire Officer I certification through the commission; and

(3) hold, as a minimum, [~~intermediate~~] Fire Service Instructor I certification[~~, or intermediate fire education specialist certification~~] through the commission; and

(A) [~~(4)~~] possess valid documentation of accreditation from the International Fire Service Accreditation Congress as Fire Officer II; or

(B) [~~(5)~~] complete a commission approved Fire Officer II program and successfully pass the commission examination as specified in Chapter 439 of this title (relating to Examinations for Certification). An approved Fire Officer II program must consist of one of the following:

(i) [~~(A)~~] completion of a commission approved Fire Officer II Curriculum as specified in Chapter 9 of the commission's Certification Curriculum Manual;

(ii) [~~(B)~~] completion of an out-of-state training program that has been submitted to the commission for evaluation and found to be equivalent to or exceed the commission approved Fire Officer II Curriculum;

(iii) [~~(C)~~] completion of a military training program that has been submitted to the commission for evaluation and found to be equivalent or exceed the commission approved Fire Officer II Curriculum; or

(iv) [~~(D)~~] successful completion of 18 college semester hours consisting of the following courses or their equivalent:

(I) [~~(i)~~] Fire Prevention Codes and Inspections, 3 semester hours;

(II) [~~(ii)~~] Fire and Arson Investigation I or II, 3 semester hours;

(III) [~~(iii)~~] Fire Administration I, 3 semester hours;

(IV) [~~(iv)~~] Fire Administration II, 3 semester hours;

(V) [~~(v)~~] Firefighting Strategies and Tactics I or II, 3 semester hours; and

(VI) [~~(vi)~~] Company Fire Officer, 3 semester hours.

(b) - (c) (No change.)

(d) No individual will be permitted to take the commission examination for Fire Officer II certification unless the individual documents completion of the Fire Fighter I and Fire Fighter II level training as required by Chapter 1, Basic Fire Suppression, of the commission's Certification Curriculum Manual and holds, as a minimum, [~~intermediate~~] Fire Service Instructor I certification[~~, intermediate fire education specialist certification or associate instructor certification~~] through the commission, or documents accreditation from International Fire Service Accreditation Congress as an Instructor I.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 18. MOTOR CARRIERS

The Texas Department of Transportation (department) proposes amendments to §18.2, concerning definitions, §§18.13, 18.14, 18.16, 18.17 and repeal of §18.18, concerning motor carrier registration, and amendments to §18.32, concerning motor carrier records, §§18.51, 18.58, and 18.63 - 18.65, concerning consumer protection, and §§18.82, 18.87 - 18.93, and 18.96, concerning vehicle storage facilities.

EXPLANATION OF PROPOSED AMENDMENTS AND REPEAL

The proposed amendments and repeal are necessary to implement the provisions of House Bills 480, 1018, 1584, 2630, and 2702 of the 79th Legislature, Regular Session, 2005; update statutory references; clarify existing information; and address the implementation of online registration applications.

House Bill 480 amended Occupations Code, §2303.155 to increase the notification charge a vehicle storage facility operator can charge, from $32 to $50, and to increase the daily storage fee of a vehicle by $5. House Bill 480 added §2303.158 to clarify the condition under which a person claiming to be the vehicle owner of a towed vehicle can access their vehicle's interior storage in order to prove ownership.

House Bill 1018 addressed commercial school bus regulations, providing an additional insurance level for certain commercial school buses and requiring a minimum liability insurance of at least $500,000 combined single limit.

House Bill 2630 addressed issues with vehicle storage facilities. It requires the name, address, and telephone number of the justice court be included in the contents of the notices provided to the owners of towed vehicles. House Bill 2630 also amends Occupations Code, §2303.152(a) and (e) to allow vehicle storage facility operators to issue notice by publication for vehicles not registered in Texas for nonconsent storage when a vehicle owner's identity or vehicle's state of registration cannot be determined. It requires vehicle storage facility operators to notify law enforcement when a vehicle has been abandoned at a vehicle storage facility. House Bill 2630 also adds language to prohibit vehicle storage facilities from charging additional fees related to storage other than fees set forth in statute.

House Bill 2702, Article 6, eliminated alternative motor carrier registration requirements previously based on vehicle weight, thus eliminating the reference to "Type A" and "Type B" household goods carriers. Throughout the proposed rules, all references to "Type A" and "Type B" household goods carriers are deleted.

House Bill 480, House Bill 1584 and House Bill 2630 all added language to require a vehicle storage facility operator to accept either electronic checks, debit cards, or credit cards as an alternative form of payment for vehicle storage charges.

New §18.2(6)(A)(vi) expands the definition of commercial motor vehicle to include any vehicle transporting household goods for compensation as required by House Bill 2702. Proposed amendment to §18.2(6)(B)(ii) updates the legal reference for cotton vehicles registration and proposed amendment to §18.2(7) adds a new definition for "commercial school bus" to comply with House Bill 1018.

Section 18.13(a)(3), relating to application for motor carrier registration, deletes the reference to the application to address the implementation of a new online registration process. The online registration process will streamline the application procedures and allow for a more efficient system.

Section 18.14(b)(1), relating to expiration and renewal of commercial motor vehicle registration, allows the department to provide renewal notices by electronic mail to address the implementation of new online registration applications.

Section 18.16(a), relating to insurance requirements, including numbered item 1, and §18.16(b), (c), (e), (f), and (h), comply with the requirements of House Bill 2702 regarding commercial household goods carriers. Minimum levels of liability insurance for household goods carriers with gross weight less than 26,000 pounds is set at $300,000 based on existing federal requirements. Letters of credit applied only to Type B household goods carriers, therefore, all references to letters of credit and the process for acceptance have been removed in the proposed language. The proposed rule also deletes references to surety bonds as they do not apply to motor carriers that are required to register. In addition, changes are proposed to §18.16(c)(1) to make the language consistent with the statute.

Numbered item 5 is added to the figure §18.16(a) to comply with the requirements of House Bill 1018 regarding commercial school buses. The proposed rule sets the minimum insurance level at $500,000 as required by the statute. The remaining items

are renumbered accordingly. The phrase "and household good carriers" is added to numbered item 1 in the figure. The word "of" is changed to "or" in renumbered item 11 of the figure to correct a grammatical error.

Section 18.17, Single State Registration System, addresses implementation of a new online Single State Registration System (SSRS) and clarifies methods used to send SSRS renewal applications to customers. The proposed deletion of language in §18.17(j)(6) eliminates duplicate insurance filing. The new system connects directly with the Federal Motor Carrier Safety Administration (FMCSA), therefore, it is no longer necessary to have the motor carrier file the insurance information with both entities.

Section 18.18, Temporary Registration of International Motor Carriers, is repealed to comply with 49 CFR, Parts 365 and 385, effective March 19, 2002. The federal regulations now require that motor carriers from Mexico obtain operating authority through the FMCSA. With the federal change, temporary registration stamps are no longer necessary.

Section 18.58(c)(1)(B), relating to moving services contract - options for carrier limitation of liability, changes the language to be consistent with the provisions of the household goods carriers contract terms and conditions used in interstate movements.

Section 18.82(8), Definitions (Main entrance), reflects a recent administrative decision to clarify that a vehicle storage facility's main entrance is located at the point where a public road meets private property leading to the vehicle storage facility. The proposed change will help address problems consumers have in locating the facility.

New §18.82(15), Vehicle transfer, is defined as "any movement of a vehicle out of a VSF, prior to its release as prescribed in §18.92(a)." Currently, this term is interpreted in a way that limits the release of a vehicle to a person other than another vehicle storage facility.

Section 18.87(b)(2), relating to notifications regarding towed vehicles, clarifies that the notification procedures apply to vehicles not registered in Texas. The amendment to §18.87(b)(2)(B) allows vehicle storage facilities to utilize publication to notify the owner of the vehicle if the vehicle does not display a license plate or vehicle inspection certificate and the storage facility cannot determine ownership and lienholder information. This change is necessary to comply with House Bill 2630.

Section 18.89, Notice of Complaint Procedure, requires the notice of complaint procedures be included on the front page of the bill for service. This is to ensure that the information is accessible to the consumer.

Section 18.90, Rights of Owner or Authorized Representative, is amended to comply with House Bill 480 regarding access to a vehicle's interior to prove ownership.

Section 18.91(b), pertaining to facility requirements, adds a new requirement that VSF operators provide a consumer with safe unobstructed access to a vehicle in order to establish ownership, and clarifies signage requirements.

Section 18.92, Technical Requirements, implements House Bill 2630 regarding the requirement that the vehicle storage facility provide information on the justice court that has jurisdiction and the law enforcement agency that authorized the tow.

Section 18.92 requires the acceptance of new methods of payment for nonconsent storage as required by House Bill 480, House Bill 2630, and House Bill 1584. The vehicle storage facility is required to accept either electronic checks, debit cards, or credit cards as an alternative form of payment for fees associated with the towing and storage of the vehicle.

Section 18.92 prohibits a vehicle storage facility from refusing to release a vehicle impounded for evidentiary or examination purpose because a law enforcement agency has not paid the cost of towing and storage. In addition, the section is amended to comply with 37 TAC §4.16, that prohibits the release of a commercial motor vehicle until delinquent penalties have been paid by the motor carrier.

Amendments to §18.93, Storage Fees and Charges, is amended to implement House Bills 480 and 2630 regarding fee increases and charge restrictions.

Amendments to §18.96(c), pertaining to disposal of certain vehicles, implements House Bill 2630 regarding notification to law enforcement of a vehicle abandoned at a vehicle storage facility.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each of the first five years the amendments and repeal as proposed are in effect, there will be minimal fiscal implications for state or local governments as a result of enforcing or administering the amendments and repeal. There are minimal anticipated economic costs for persons required to comply with the sections as proposed. The minimal fiscal impact is due to rule changes mandated by recently enacted legislation, regarding changes to household goods mover requirements, a new requirement that vehicle storage facilities accept payment by either electronic check, credit card, or debit card, and changes in vehicle storage facility charges.

Carol Davis, Director, Motor Carrier Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments and repeal.

PUBLIC BENEFIT

Ms. Davis has also determined that for each of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments and repeal will be the implementation of the legislation referenced in this preamble, clarification of terms used in this chapter and of requirements for motor carriers and vehicle storage facilities, and increased protection of the traveling public and the transportation infrastructure. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments and repeal may be submitted to Carol Davis, Director, Motor Carrier Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 2, 2006.

SUBCHAPTER A. GENERAL PROVISIONS

43 TAC §18.2

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically,

Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Approved association--A group of household goods carriers, its agents, or both, that has an approved collective ratemaking agreement on file with the department under §18.64 of this chapter.

(2) Binding proposal--A formal written offer stating the exact price for the transportation of specified household goods and any related services.

(3) Certificate of insurance--A certificate prescribed by and filed with the department in which an insurance carrier or surety company warrants that a motor carrier for whom the certificate is filed has the minimum coverage as required by §18.16 and §18.86 of this chapter.

(4) Certificate of registration--A certificate issued by the department to a motor carrier and containing a unique number.

(5) Certified scale--Any scale designed for weighing motor vehicles, including trailers or semitrailers not attached to a tractor, and certified by an authorized scale inspection and licensing authority. A certified scale may also be a platform-type or warehouse-type scale properly inspected and certified.

(6) Commercial motor vehicle--

(A) Includes:

(i) any motor vehicle or combination of vehicles with a gross weight, registered weight, or gross weight rating in excess of 26,000 pounds, that is designed or used for the transportation of cargo in furtherance of any commercial enterprise;

(ii) all tow trucks, regardless of the gross weight rating of the tow truck;

(iii) any vehicle, including buses, designed or used to transport more than 15 passengers, including the driver;

(iv) any vehicle used in the transportation of hazardous materials in a quantity requiring placarding under the regulations issued under the federal Hazardous Materials Transportation Act (49 USC, App. §§1801-1813); [~~and~~]

(v) a commercial motor vehicle, as defined by 49 CFR §390.5, owned or controlled by a person or entity that is domiciled in or a citizen of a country other than the United States; and[~~.~~]

(vi) any vehicle transporting household goods for compensation, regardless of the gross weight rating, registered weight or gross weight.

(B) Does not include:

(i) a farm vehicle with a gross weight, registered weight, and gross weight rating of less than 48,000 pounds;

(ii) cotton vehicles registered under Transportation Code, §504.505 [~~§502.277~~];

(iii) a vehicle registered with the Railroad Commission under Texas Natural Resources Code, §113.131 and §116.072;

(iv) a vehicle transporting liquor under a private carrier permit issued in accordance with Alcoholic Beverage Code, Chapter 42;

(v) a motor vehicle used to transport passengers and operated by an entity whose primary function is not the transportation of passengers, such as a vehicle operated by a hotel, day-care center, public or private school, nursing home, or similar organization;

(vi) a motor vehicle registered under the Single State Registration System established under 49 USC §14504 when operating exclusively in interstate or international commerce; and

(vii) a vehicle operated by a governmental entity.

(7) Commercial school bus--A motor vehicle owned by a motor carrier that is:

(A) registered under Transportation Code, Chapter 643, Subchapter B;

(B) operated exclusively within the boundaries of a municipality and used to transport preprimary, primary, or secondary school students on a route between the students' residences and a public, private, or parochial school or daycare facility;

(C) operated by a person who holds a driver's license or commercial driver's license of the appropriate class for the operation of a school bus;

(D) complies with Transportation Code Chapter 548; and

(E) complies with Transportation Code, §521.022.

(8) [~~(7)~~] Commission--The Texas Transportation Commission.

(9) [~~(8)~~] Consent tow--Any tow of a motor vehicle initiated by the owner or operator of the vehicle or by a person who has possession, custody, or control of the vehicle. The term does not include a tow of a motor vehicle initiated by a peace officer investigating a traffic accident or a traffic incident that involves the vehicle.

(10) [~~(9)~~] Conspicuous--Written in a size, color, and contrast so as to be readily noticed and understood.

(11) [~~(10)~~] Conversion--A change in an entity's organization that is implemented with a Certificate of Conversion issued by the Texas Secretary of State under Texas Business Corporation Act, Article 5.18 [~~5.17~~].

(12) [~~(11)~~] Department--Texas Department of Transportation.

(13) [~~(12)~~] Director--The director of the Motor Carrier Division, Texas Department of Transportation.

(14) [~~(13)~~] Division--The Motor Carrier Division.

(15) [~~(14)~~] DOI--Texas Department of Insurance.

(16) [~~(15)~~] Estimate--An informal oral calculation of the approximate price of transporting household goods.

(17) [~~(16)~~] Farmer--A person who operates a farm or is directly involved in cultivating land or in raising crops or livestock that are owned by or are under the direct control of that person.

(18) [~~(17)~~] Farm vehicle--Any vehicle or combination of vehicles controlled or operated by a farmer or rancher being used to

transport agriculture products, farm machinery, and farm supplies to or from a farm or ranch.

(19) [~~(18)~~] Gross weight rating--The maximum loaded weight of any combination of truck, tractor, and trailer equipment as specified by the manufacturer of the equipment. If the manufacturer's rating is unknown, the gross weight rating is the greater of:

(A) the actual weight of the equipment and its lading; or

(B) the maximum lawful weight of the equipment and its lading.

(20) [~~(19)~~] Household goods--Personal property intended ultimately to be used in a dwelling when the transportation of that property is arranged and paid for by the householder or the householder's representative. The term does not include personal property to be used in a dwelling when the property is transported from a manufacturing, retail, or similar company to a dwelling if the transportation is arranged by a manufacturing, retail, or similar company.

(21) [~~(20)~~] Household goods agent--A motor carrier who transports household goods on behalf of another motor carrier.

(22) [~~(21)~~] Household goods carrier--A motor carrier who transports household goods for compensation or hire in furtherance of a commercial enterprise.

(23) [~~(22)~~] Insurer--A person, including a surety, authorized in this state to write lines of insurance coverage required by Subchapter B and Subchapter G of this chapter.

(24) [~~(23)~~] Inventory--A list of the items in a household goods shipment and the condition of the items.

(25) [~~(24)~~] Leasing business--A person that leases vehicles requiring registration under Subchapter B of this chapter to a motor carrier that must be registered.

(26) [~~(25)~~] Manager--The manager of the department's Motor Carrier Division, Motor Carrier Operations Section.

(27) [~~(26)~~] Mediation--A non-adversarial form of alternative dispute resolution in which an impartial person, the mediator, facilitates communication between two parties to promote reconciliation, settlement, or understanding.

(28) [~~(27)~~] Motor Carrier or carrier--A person that controls, operates, or directs the operation of one or more vehicles that transport persons or cargo over a public highway in this state.

(29) [~~(28)~~] Motor transportation broker--A person who sells, offers for sale, or negotiates for the transportation of cargo by a motor carrier operated by another person or a person who aids and abets another person in selling, offering for sale, or negotiating for the transportation of cargo by a motor carrier operated by another person.

(30) [~~(29)~~] Moving services contract--A contract between a household goods carrier and shipper, such as a bill of lading, receipt, order for service, or work order, that sets out the terms of the services to be provided.

(31) [~~(30)~~] Multiple user--An individual or business who has a contract with a household goods carrier and who used the carrier's services more than 50 times within the preceding 12 months.

(32) [~~(31)~~] Nonconsent tow--Any tow of a motor vehicle that is not a consent tow.

(33) [~~(32)~~] Not-to-exceed proposal--A formal written offer stating the maximum price a shipper can be required to pay for the transportation of specified household goods and any related services. The offer may also state the non-binding approximate price. Any offer based on hourly rates must state the maximum number of hours required for the transportation and related services unless there is an acknowledgment from the shipper that the number of hours is not necessary.

(34) [~~(33)~~] Principal place of business--A single location that serves as a motor carrier's headquarters and where it maintains its operational records or can make them available.

(35) [~~(34)~~] Public highway--Any publicly owned and maintained street, road, or highway in this state.

(36) [~~(35)~~] Reasonable dispatch--The performance of transportation, other than transportation provided under guaranteed service dates, during the period of time agreed on by the carrier and the shipper and shown on the shipment documentation. This definition does not affect the availability to the carrier of the defense of force majeure.

(37) [~~(36)~~] Registration receipt--A receipt issued to the registrant by its registration state after the requirements of 49 CFR, Part 367 have been met.

(38) [~~(37)~~] Registration state--A state where the registrant maintains a valid single state registration as defined in 49 CFR, Part 367.

(39) [~~(38)~~] Replacement vehicle--A vehicle that takes the place of another vehicle that has been removed from service.

(40) [~~(39)~~] Revocation--The withdrawal of registration and privileges by the department or a registration state.

(41) [~~(40)~~] Shipper--The owner of household goods or the owner's representative.

(42) [~~(41)~~] Short-term lease--A lease of 30 days or less.

(43) [~~(42)~~] Single state registration system--The program established by 49 USC §14504.

(44) [~~(43)~~] SOAH--The State Office of Administrative Hearings.

(45) [~~(44)~~] State of travel--A state in which a motor carrier operates motor vehicles subject to the single state registration system.

(46) [~~(45)~~] Substitute vehicle--A vehicle that is leased from a leasing business and that is used as a temporary replacement for a vehicle that has been taken out of service for maintenance, repair, or any other reason causing the temporary unavailability of the permanent vehicle.

(47) [~~(46)~~] Suspension--Temporary removal of privileges granted to a registrant by the department or a registration state.

(48) [~~(47)~~] Towing company--A motor carrier that transports vehicles using a tow truck.

(49) [~~(48)~~]) Tow--The utilization of a mechanical device used to winch or otherwise move another vehicle.

(50) [~~(49)~~] Tow truck--A motor vehicle equipped with or used in combination with a mechanical device used to tow, winch, or otherwise move another vehicle. The following motor vehicles are not considered tow trucks:

(A) a motor vehicle owned and used exclusively by a governmental entity, including a public school district;

(B) a motor vehicle towing:

(i) a race car;

(ii) a motor vehicle for exhibition; or

(iii) an antique motor vehicle;

(C) a recreational vehicle towing another vehicle;

(D) a motor vehicle used in combination with a tow bar, tow dolly, or other mechanical device if the vehicle is not operated in the furtherance of a commercial enterprise; or

(E) a motor vehicle that is controlled or operated by a farmer or rancher and that is used for towing a farm vehicle.

~~[(50) Type A household goods carrier--A household goods carrier that uses at least one motor vehicle or combination of vehicles with a gross weight, registered weight, or gross weight rating in excess of 26,000 pounds.]~~

~~[(51) Type B household goods carrier--A household goods carrier that does not use a motor vehicle or combination of vehicles with a gross weight, registered weight, or gross weight rating in excess of 26,000 pounds.]~~

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505334
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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SUBCHAPTER B. MOTOR CARRIER REGISTRATION

43 TAC §§18.13, 18.14, 18.16, 18.17

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.13. Application for Motor Carrier Registration.

(a) Form of application. An application for motor carrier registration must be filed with the department's Motor Carrier Division and [~~except as provided in subsection (i) of this section,~~] must be in the form prescribed by the director and must contain, at a minimum, the following information.

(1) Business or trade name. The applicant must designate the business or trade name of the motor carrier.

(2) Owner name. If the motor carrier is a sole proprietorship, the owner must indicate the name and social security number of the owner. A partnership must indicate the partners' names, and a corporation must indicate principal officers and titles.

(3) Principal place of business. A motor carrier must disclose [~~designate on the application~~] the motor carrier's principal business address. If the mailing address is different from the principal business address, the mailing address must also be disclosed [~~designated on the application~~].

(4) Legal Agent.

(A) A Texas-domiciled motor carrier must provide the name and address of a legal agent for service of process if the agent is different from the motor carrier.

(B) A motor carrier domiciled outside Texas must provide the name and Texas address of the legal agent for service of process.

(C) A legal agent for service of process shall be a Texas resident, a domestic corporation, or a foreign corporation authorized to transact business in Texas with a Texas address for service of process.

(5) Description of vehicles. An application must include a motor carrier equipment report identifying each commercial motor vehicle that requires registration and that the carrier proposes to operate. Each commercial motor vehicle must be identified by its motor vehicle identification number, make, model year, and type of cargo and by the unit number assigned to the commercial motor vehicle by the motor carrier. Any subsequent registration of vehicles must be made under subsection (e) of this section.

(6) Type of motor carrier operations. An applicant must state if the applicant:

(A) proposes to transport passengers, household goods, or hazardous materials;

(B) is a tow truck company that performs nonconsent tows; or

(C) is domiciled in a foreign country.

(7) Insurance coverage. An applicant must indicate insurance coverage as required by §18.16 of this subchapter.

(8) Safety affidavit. Each motor carrier must complete, as part of the application, an affidavit stating that the motor carrier knows and will conduct operations in accordance with all federal and state safety regulations.

(9) Drug-testing certification. Each motor carrier must certify, as part of the application, that the motor carrier is in compliance with the drug-testing requirements of 49 C.F.R. Part 382.

(A) Drug-testing consortium participants. If the motor carrier belongs to a consortium, as defined by 49 C.F.R. Part 382, the applicant must provide the names of the persons operating the consortium.

(B) Report of positive result. A motor carrier required to register under this section shall report to the Department of Public Safety, in the manner required by the Department of Public Safety, a valid positive result on a controlled substances test performed as part of the carrier's drug testing program on an employee of the carrier who holds a commercial driver's license under Transportation Code, Chapter 522. The term "employee" as used in this subparagraph includes all employees as defined in Title 49, Code of Federal Regulations, Part 40.3.

(10) Duration of registration. An applicant must indicate the duration of the desired registration. Registration may be for seven calendar days or for 90 days, one year, or two years. The duration of registration chosen by the applicant will be applied to all vehicles. Household goods carriers may not obtain seven day or 90 day certificates of registration.

(11) Additional requirements. The following fees and information must be submitted with all applications.

(A) An application must be accompanied by an application fee of:

(i) $100 for annual and biennial registrations;

(ii) $25 for 90 day registrations; or

(iii) $5 for seven day registrations.

(B) An application must be accompanied by a vehicle registration fee of:

(i) $10 for each vehicle, other than a tow truck, requiring registration or $25 for each tow truck that the motor carrier proposes to operate under a seven day, 90 day, or annual registration; or

(ii) $20 for each vehicle, other than a tow truck, requiring registration or $50 for each tow truck that the motor carrier proposes to operate under a biennial registration.

(C) An application must be accompanied by proof of insurance or financial responsibility and insurance filing fee as required by §18.16 of this subchapter.

(D) An application must be accompanied by any other information required by law.

(12) Application of fees. Applicants who have paid vehicle fees under §18.17 of this subchapter may request that the department apply those fees to the carrier's motor carrier registration. The request must be accompanied by a copy of the Single State Registration receipt. On review of the Single State Registration receipt, the department will apply fees paid under the Single State Registration System as follows.

(A) The per vehicle fees paid by the applicant will be applied on a per vehicle basis toward the vehicle fees that the applicant owes for the vehicles registered under motor carrier registration.

(B) Vehicle fees will be applied only to the first year of registration if an applicant applies for a biennial motor carrier registration. The motor carrier must pay all vehicle fees for the second year.

(b) Incomplete applications. The director will return an application to the applicant if it is not accompanied by all fees and by proof of insurance or financial responsibility.

(c) Conditional acceptance of application. The director may conditionally accept an application if it is accompanied by all fees and by proof of insurance or financial responsibility, but is not accompanied by all required information. Conditional acceptance in no way constitutes approval of the application. The director will notify the applicant of any information necessary to complete the application. If the applicant does not supply all necessary information within 45 days from notification by the director, the application will be considered withdrawn and all fees will be retained.

(d) Disposition of application.

(1) Approval. An applicant meeting the requirements of this section and whose registration is approved will be issued the following documents.

(A) Certificate of registration. The department will issue a certificate of registration. The certificate of registration will contain the name and address of the motor carrier and a single registration number, regardless of the number of vehicles requiring registration that the carrier operates.

(B) Insurance cab card. The department will issue an original insurance cab card listing all vehicles to be operated under the carrier's certificate of registration. The insurance cab card shall be continuously maintained at the registrant's principal place of business. The insurance cab card will be valid for the same period as the motor carrier's certificate of registration and will contain information regarding each vehicle registered by the motor carrier. [~~This subparagraph does not apply to Type B household goods carriers.~~]

(i) A copy of the page of the insurance cab card on which the vehicle is shown shall be maintained in each vehicle listed. The appropriate information concerning that vehicle shall be highlighted. The insurance cab card will serve as proof of insurance as long as the motor carrier has continuous insurance or financial responsibility on file with the department.

(ii) On demand by a department-certified inspector or any other authorized government personnel, the driver shall present the highlighted page of the insurance cab card that is maintained in the vehicle.

(iii) The carrier shall notify the department in writing if it discontinues use of a registered commercial motor vehicle before the expiration of its insurance cab card.

(iv) Any erasure, alteration, or unauthorized use of an insurance cab card renders it void.

(v) If an original insurance cab card is lost, stolen, destroyed, or mutilated, if it becomes illegible, or if it otherwise requires replacement, a new insurance cab card will be issued by the department at the request of the motor carrier.

(vi) Registration listings previously issued by the department will remain valid until expiration or renewal or until revoked or suspended by the department.

(2) Denial. The department may deny a registration if the applicant had a registration revoked under §18.72 of this chapter.

(e) Additional and Replacement Vehicles. A motor carrier required to obtain a certificate of registration under this section shall not operate additional vehicles unless the carrier identifies the vehicles on a form prescribed by the director and pays applicable fees as described in this subsection.

(1) Additional vehicles. To add a vehicle, a motor carrier must pay a fee of $10 for each additional vehicle, other than a tow truck, or $25 for each tow truck that the motor carrier proposes to operate under a seven day, 90 day, or annual registration. To add a vehicle during the first year of a biennial registration, a motor carrier must pay a fee of $20 for each vehicle, other than a tow truck, or $50 for each tow truck. To add a vehicle during the second year of a biennial registration, a motor carrier must pay a fee of $10 for each vehicle, other than a tow truck, or $25 for each tow truck.

(2) Replacement vehicles. No fee is required for a vehicle that is replacing a vehicle for which the fee was previously paid. Before the replacement vehicle is put into operation, the motor carrier shall notify the department, identify the vehicle being taken out of service, and identify the replacement vehicle on a form prescribed by the department. A motor carrier registered under seven day registration may not replace vehicles.

(3) Fees paid under the Single State Registration System. Vehicle fees paid under §18.17 of this subchapter will be applied toward a motor carrier's vehicle fees under subsection (a)(12) of this section.

(f) Supplement to original application. A motor carrier required to register under this section shall submit a supplemental application under the following circumstances.

(1) Change of cargo. A registered motor carrier may not begin transporting household goods or hazardous materials, or performing nonconsent tows, unless the carrier submits a supplemental application to the department and shows the department evidence of insurance or financial responsibility in the amounts specified by §18.16 of this subchapter.

(2) Change of name. A motor carrier that changes its name shall file a supplemental application for registration no later than the effective date of the change. The motor carrier shall include evidence of insurance or financial responsibility in the new name and in the amounts specified by §18.16 of this subchapter. A motor carrier that is a corporation must have its name change approved by the Texas Secretary of State before filing a supplemental application. A motor carrier incorporated outside the State of Texas must complete the name change under the law of its state of incorporation before filing a supplemental application.

(3) Change of address or legal agent for service of process. A motor carrier shall file a supplemental application for any change of address or any change of its legal agent for service of process no later than the effective date of the change. The address most recently filed will be presumed conclusively to be the current address.

(4) Change in principal officers and titles. A motor carrier that is a corporation shall file a supplemental application for any change in the principal officers and titles no later than the effective date of the change.

(5) Conversion of corporate structure. A motor carrier that has successfully completed a corporate conversion involving a change in the name of the corporation shall file a supplemental application for registration and evidence of insurance or financial responsibility reflecting the new company name. The conversion must be approved by the Texas Secretary of State before the supplemental application is filed.

(6) Change in drug-testing consortium status. A motor carrier that changes consortium status shall file a supplemental application that includes the names of the persons operating the consortium.

(7) Retaining a revoked or suspended certificate of registration number. A motor carrier may retain a prior certificate of registration number by:

(A) filing a supplemental application to re-register instead of filing an original application; and

(B) providing adequate evidence that the carrier has satisfactorily resolved the facts that gave rise to the suspension or revocation.

(g) Change of ownership. A motor carrier must file an original application for registration when there is a corporate merger or a change in the ownership of a sole proprietorship or of a partnership.

(h) Alternative vehicle registration for household goods agents. To avoid multiple registrations of a commercial motor vehicle, a household goods agent's vehicles may be registered under the motor carrier's certificate of registration under this subsection.

(1) The carrier must notify the department on a form approved by the director of its intent to register its agent's vehicles under this subsection.

(2) When a carrier registers vehicles under this subsection, the carrier's certificate will include all vehicles registered under its agent's certificates of registration. The carrier must register under its certificate of registration all vehicles operated on its behalf that do not appear on its agent's certificate of registration.

(3) The department may send the carrier a copy of any notification sent to the agent concerning circumstances that could lead to denial, suspension, or revocation of the agent's certificate.

~~[(i) Type B household goods carriers. An application for motor carrier registration submitted by a Type B household goods carrier shall be in the form prescribed by the director.]~~

~~[(1) The carrier's application must contain all the information described in subsection (a) of this section, except for the information specified in subsection (a)(5) and (7) of this section.]~~

~~[(2) The carrier's application must be accompanied by a $100 application fee.]~~

~~[(3) The carrier's application must be accompanied by proof of financial responsibility for cargo loss or damage and by the filing fee specified in §18.16 of this subchapter.]~~

~~[(4) The carrier's application must include a statement certifying that the carrier:]~~

~~[(A) is in compliance with Transportation Code, Chapter 601; and]~~

~~[(B) if the carrier maintains an automobile liability insurance policy to comply with Transportation Code, Chapter 601, then the policy is an enforceable commercial or business automobile liability insurance policy.]~~

~~[(5) The department will issue an original certificate of registration, which must be continuously maintained at the registrant's principal place of business.]~~

~~[(6) A carrier shall carry a copy of its certificate of registration either in the cab of each vehicle or in each trailer used for the transportation of household goods.]~~

~~[(7) The carrier shall notify the department in writing when it discontinues operations as a transporter of household goods.]~~

~~[(8) On demand by a department-certified inspector or any other authorized government personnel, the driver shall present the certificate of registration maintained in the vehicle.]~~

~~[(9) The certificate of registration is continuously in effect until suspended or revoked by the department. A motor carrier may voluntarily cancel the certificate of registration by submitting a supplemental application or written request.]~~

~~[(10) Any erasure, alteration, or unauthorized use of a certificate of registration renders it void.]~~

(i) ~~[(j)]~~ Substitute vehicles leased from leasing businesses. A registered motor carrier is not required to comply with the provisions of subsection (e) of this section for a substitute vehicle leased from a business registered under §18.19 of this subchapter. A motor carrier is not required to carry proof of registration as described in subsection (d) of this section if a copy of the lease agreement for the originally leased vehicle is carried in the cab of the temporary replacement vehicle.

§18.14. Expiration and Renewal of Commercial Motor Vehicle Registration.

(a) Expiration and renewal dates.

(1) A motor carrier with annual or biennial registration[~~, other than a Type B household goods carrier,~~] will be assigned a date for the expiration and renewal of its motor carrier registration according to the last digit of the carrier's certificate of registration number, as outlined in the following chart:
Figure: 43 TAC §18.14(a)(1) (No change.)

[~~(2) Certificates of registration for Type B household goods carriers remain in effect until suspended or revoked.~~]

(2) [~~(3)~~] 90 day certificates of registration are valid for 90 calendar days from the effective date.

(3) [~~(4)~~] Seven day certificates of registration are valid for seven calendar days from the effective date.

(b) Registration renewal.

(1) Approximately 60 days before the expiration of registration, the department will mail or send electronically a renewal notice to each registered motor carrier with annual or biennial registration [~~, other than a Type B household goods carrier. The notice will be mailed to the carrier's last known address according to the division's records~~]. Failure to receive the notice does not relieve the registrant of the responsibility to renew. A motor carrier must ensure that the department receives the renewal at least 15 days prior to the renewal date specified in subsection (a) of this section. A supplement to an application for motor carrier registration renewal must:

(A) supply any new information required under §18.13(f) of this subchapter if the information has not previously been supplied to the department;

(B) include a $10 fee for each vehicle, other than a tow truck, requiring registration or $25 for each tow truck that the carrier operates under an annual certificate of registration and a $20 fee for each vehicle, other than a tow truck, requiring registration or $50 for each tow truck that the carrier operates under a biennial certificate of registration; and

(C) include a copy of the Single State Registration receipt when requesting that vehicle fees paid under §18.17 of this subchapter be applied toward the fees specified by this subsection.

(2) Seven day and 90 day registrations may not be renewed.

(3) A motor carrier shall maintain continuous insurance or evidence of financial responsibility in an amount at least equal to the amount prescribed under §18.16 of this subchapter.

(4) The insurance cab card issued to a motor carrier is valid for the same period as the motor carrier's certificate of registration.

(5) To renew registration after it has expired, a motor carrier must identify its vehicles on a form prescribed by the director, pay all vehicle fees, and if current proof of insurance is not on file with the division, meet all insurance requirements.

§18.16. Insurance Requirements.

(a) Automobile liability insurance requirements.

[~~(1)~~] A motor carrier[~~, other than a Type B household goods carrier,~~] must file proof of commercial automobile liability insurance with the department on a form acceptable to the director for each vehicle required to be registered under this subchapter. The motor carrier must carry and maintain automobile liability insurance that is combined single limit liability for bodily injury to or death of an individual per occurrence, loss or damage to property (excluding cargo) per occurrence, or both. Extraneous information will not be considered acceptable, and the department may reject proof of commercial automobile liability insurance if it is provided in a format that includes information beyond what is required. Minimum insurance levels are indicated in the following table.
Figure: 43 TAC §18.16(a)[~~(1)~~]

[~~(2) Type B household goods carriers shall comply with the applicable requirements of Transportation Code, Chapter 601. If a Type B household goods carrier maintains an automobile liability insurance policy to comply with Transportation Code, Chapter 601, the policy must be an enforceable commercial or business automobile liability insurance policy.~~]

(b) Cargo insurance.

(1) Household [~~Type A household goods carriers. A Type A household~~] goods carriers [~~carrier~~] shall file and maintain with the department proof of financial responsibility.

(A) The minimum limits of financial responsibility for a household goods carrier for hire is $5,000 for loss or damage to a single shipper's cargo carried on any one motor vehicle.

(B) The minimum limits of financial responsibility for a household goods carrier for hire is $10,000 for aggregate loss or damage to multiple shipper cargo carried on any one motor vehicle. In cases in which multiple shippers sustain damage and the aggregate amount of cargo damage is greater than the cargo insurance in force, the insurance company shall prorate the benefits among the shippers in relationship to the damage incurred by each shipper.

[~~(2) Type B household goods carriers. A Type B household goods carrier shall file and maintain with the department proof of financial responsibility.~~]

[~~(A) The minimum level of financial responsibility for loss or damage to total cargo carried on any one motor vehicle is a $5,000.~~]

[~~(B) The minimum level of financial responsibility for aggregate loss or damage to multiple shipper cargo carried on any one motor vehicle is $5,000. In cases in which multiple shippers sustain damage and the aggregate amount of cargo damage is greater than the cargo insurance in force, the insurance company shall prorate the benefits among the shippers in relationship to the damage incurred by each shipper.~~]

(2) [~~(3)~~] Tow truck company performing nonconsent tows. A tow truck company that performs nonconsent tows shall file and maintain with the department proof of financial responsibility for on-hook cargo. The minimum level of financial responsibility for each registered vehicle performing nonconsent tows will be in the amount of at least $50,000.

(c) Workers' compensation or accidental insurance coverage.

(1) If a motor carrier is required to register under this subchapter, if its primary business is transportation for compensation or hire[~~, and if it operates~~] between two or more municipalities [~~incorporated cities, towns, or villages~~], the carrier shall provide workers' compensation for all its employees or accidental insurance coverage in the amounts prescribed in paragraph (2) of this subsection. [~~This subsection does not apply to Type B household goods carriers.~~]

(2) Accidental insurance coverage required by paragraph (1) of this subsection shall be at least in the following amounts:

(A) $300,000 for medical expenses and coverage for at least 104 weeks;

(B) $100,000 for accidental death and dismemberment, including 70% of employee's pre-injury income for not less than 104 weeks when compensating for loss of income; and

(C) $500 for the maximum weekly benefit.

(d) Qualification of motor carrier as self-insured.

(1) General qualifications. A motor carrier may meet the insurance requirements of subsections (a) and (b) of this section by filing an application, in a form prescribed by the department, to qualify as a self-insured. The application must include a true and accurate statement of the motor carrier's financial condition and other evidence that establishes its ability to satisfy obligations for bodily injury and property damage liability without affecting the stability or permanency of its business. The department may accept United States Department of Transportation evidence of the motor carrier's qualifications as a self-insured.

(2) Adopted final orders. The department adopts all final orders of the Railroad Commission of Texas to the extent that they concern self-insurance and were in effect on August 31, 1995. Those final orders are continued in effect until changed by order of the department.

(3) Applicant guidelines. In addition to filing an application as prescribed by the department, an applicant for self-insured status must submit materials that will allow the department to determine the following information.

(A) Applicant's net worth. An applicant's net worth must be adequate in relation to the size of its operations and the extent of its request for self-insurance authority. The applicant must demonstrate that it can and will maintain an adequate net worth.

(B) Self-insurance program. An applicant must demonstrate that it has established and will maintain a sound insurance program that will protect the public against all claims involving motor vehicles to the same extent as the minimum security limits applicable under this section. In determining whether an applicant is maintaining a sound insurance program, the department will consider:

(i) reserves;

(ii) sinking funds;

(iii) third-party financial guarantees;

(iv) parent company or affiliate sureties;

(v) excess insurance coverage; and

(vi) other appropriate aspects of the applicant's program.

(C) Safety program. An applicant must submit evidence of substantial compliance with the Federal Motor Carrier Safety Regulations as adopted by the Texas Department of Public Safety and with Transportation Code, Chapter 644.

(4) Other securities or agreements. The department may accept an application for approval of a security or agreement if satisfied that the security or agreement offered will adequately protect the public.

(5) Periodic reports. An applicant shall file annual statements, semi-annual and quarterly reports, and any other reports required by the department reflecting the applicant's financial condition and the status of its self-insurance program while the motor carrier is self-insured.

(6) Duration of self-insured status. The department may approve an applicant as a self-insured for any specific time or for an indefinite time.

(7) Revocation of self-insured status. On receiving evidence that a self-insured motor carrier's financial condition has changed, that its safety program or record is inadequate, or that it is otherwise not in compliance with this subchapter, the department may at any time require the self-insured to provide additional information. On 10 days notice from the department, the self-insured shall appear and demonstrate that it continues to have adequate financial resources to pay all claims involving motor vehicles for bodily injury and property damage liability. The self-insured shall also demonstrate that it remains in compliance with the requirements of this section and of any active self-insurance orders issued or adopted by the department. If an applicant fails to comply with this paragraph, its self-insured status may be revoked.

(8) Appeal. An applicant may appeal a denial or revocation of self-insurance status by filing a petition for an administrative hearing in accordance with §§1.21 et seq. of this title (relating to Procedures in Contested Cases).

(e) Filing proof of insurance with the department.

(1) Forms.

(A) A motor carrier must [~~, other than a Type B household goods carrier, shall file and~~] maintain proof of automobile liability insurance for all vehicles required to be registered under this subchapter at all times. This proof shall be filed on a form acceptable to the director.

(B) A household goods carrier shall file and maintain proof of cargo insurance for its cargo at all times. This proof shall be on a form acceptable to the director.

(C) A tow truck company that performs nonconsent tows shall file and maintain with the department proof of on-hook cargo insurance for all nonconsent tows. This proof shall be on a form acceptable to the director.

(2) Filing proof of insurance and financial responsibility. A motor carrier's insurance or surety company, bank, or other financial institution shall file and maintain proof of insurance or financial responsibility on a form acceptable to the director:

(A) at the time of the original application for motor carrier certificate of registration;

(B) on or before the cancellation date of the insurance coverage as described in subsection (f) of this section;

(C) when the motor carrier changes insurers;

(D) when the motor carrier asks to retain the certificate number of a revoked certificate of registration;

(E) when the motor carrier changes its name under §18.13(f)(2) of this subchapter;

(F) when the motor carrier, under subsection (a) of this section, changes the classification of the cargo being transported; and

(G) when replacing another active insurance filing.

(3) Filing fee. Each certificate of insurance or proof of financial responsibility filed with the department for the coverage required under this section shall be accompanied by a nonrefundable filing fee of $100. This fee applies both when the carrier submits an original application and when the carrier submits a supplemental application when retaining a revoked certificate of registration number.

(4) Acceptable filings. [~~Other bonds, policies or certificates.~~] The department will not accept an [~~a surety bond,~~] insurance policy[~~,~~] or certificate of insurance unless it is issued by an insurance

[~~or surety~~] company licensed and authorized to do business in the State of Texas. It must be in a form prescribed or approved by the DOI and signed or countersigned by an authorized agent of the insurance [~~or surety~~] company. The department will accept a certificate of insurance issued by a surplus lines insurer that meets the requirements of Insurance Code, Article 1.14-2, and rules adopted by the DOI under that article.

~~[(5) Letters of credit as proof of financial responsibility for Type B household goods carriers.]~~

~~[(A) The department will accept an irrevocable letter of credit if it is issued by a bank or financial institution whose deposits are guaranteed by the Federal Deposit Insurance Corporation. A letter of credit filed by a carrier must be signed or countersigned by an officer of the bank or financial institution and must comply with the following provisions at a minimum.]~~

~~*[(i)* The beneficiaries of the letter of credit must be designated clearly as cargo loss or damage claimants of the carrier. No other parties may have rights of recovery against the letter of credit. Payments under the letter of credit must be made directly to the cargo loss or damage claimant. A qualified beneficiary must establish and perfect its claims by having agreed with the motor carrier in writing on a specific amount to be paid in final settlement of the claim or by having obtained a final judgment rendered by a court of competent jurisdiction establishing the motor carrier's liability and the amount of that liability.]~~

~~*[(ii)* The letter of credit may not be revoked until after settlement of all claims arising during the time the carrier had authority from the department to use the letter of credit to satisfy cargo insurance requirements of this section. Claims must be filed with the household goods carrier within 90 days after delivery of the property or, in case of failure to make delivery, within 90 days after reasonable time for delivery has elapsed. A lawsuit must be instituted within two years and one day from the day when written notice is given by the household goods carrier to the claimant that part or all of the claim has been disallowed. When a claim is not filed or a suit is not instituted as specified in this clause, a household goods carrier shall not be held liable.]~~

~~*[(iii)* The letter of credit must state that the bank or financial institution will notify the department of cancellation of or any change in the letter of credit.]~~

~~[(B) The carrier shall provide the department with copies of an amendment or successor letter of credit no later than 30 days before the amendment or successor letter goes into effect. Any change in the terms of the letter of credit must be given prior approval by the department. Draw downs may be made only to satisfy claims for cargo loss or damage, and any draw down from the letter of credit must be reported immediately to the department if it is not replenished within seven days.]~~

~~[(C) The department retains the authority to terminate the letter of credit filing at any time if it appears to the department that the carrier's letter of credit fails to provide satisfactory protection for shippers or if the carrier fails to timely file any of the information required by the department.]~~

~~[(D) On receiving evidence that the letter of credit is no longer adequately funded, that the financial condition of a carrier with a letter of credit filing has changed, or that the carrier is otherwise not in compliance with this subchapter, the department may at any time require the carrier to provide additional information. On 10 days notice from the department, the carrier shall appear and demonstrate that it continues to have adequate letter of credit funding to pay all claims involving cargo loss or damage liability and that it remains in compliance with the requirements of this section. The department may revoke the letter of credit filing if a carrier fails to demonstrate adequate letter of credit funding to pay all claims involving cargo loss or damage or fails to comply with any requirement of this section.]~~

~~[(E) A carrier may appeal a denial or revocation of a letter of credit filing by filing a petition for an administrative hearing in accordance with §§1.21 et seq. of this title (relating to Procedures in Contested Cases).]~~

(f) Cancellation of insurance coverage. Except when replaced by another acceptable form of insurance coverage or proof of financial responsibility approved by the department, no insurance coverage[~~, surety bond, or letter of credit~~] shall be canceled or withdrawn until 30 days after notice has been given to the department by the insurance [~~or surety~~] company [~~or by the bank or financial institution~~] in a form approved by the department. Nonetheless, proof of insurance coverage for a seven day or 90 day certificate of registration may be canceled by the insurance company without 30 days notice if the certificate of registration is expired, suspended, or revoked, and the insurance company provides a cancellation date on the proof of insurance coverage. The department will revoke a certificate of registration under §18.72 of this chapter for failure to maintain proof of current insurance.

(g) Replacement insurance filing. The department will consider a new insurance filing as the current record of financial responsibility required by this section if:

(1) the new insurance filing is received by the department; and

(2) a cancellation notice has not been received for previous insurance filings.

(h) Insolvency of insurance carrier. If the insurer [~~or surety~~] of a motor carrier becomes insolvent or becomes involved in a receivership or other insolvency proceeding, the motor carrier must file [~~may apply for approval of a surety bond, insurance policy, or letter of credit issued by another surety, insurer, bank, or other financial institution by filing~~] an affidavit with the department. The affidavit must be executed by an owner, partner, or officer of the motor carrier and show that:

(1) no accidents have occurred and no claims have arisen during the insolvency of the insurance carrier[~~, surety, bank, or other financial institution~~]; or

(2) all claims have been satisfied.

(i) Notifications. The department shall notify the Texas Department of Public Safety and other law enforcement agencies of each motor carrier whose certificate of registration has been revoked for failing to maintain liability insurance coverage.

§18.17. Single State Registration System.

(a) Applicability. The State of Texas, through the department, participates in the single state registration system established by §4005 of Title IV of the Intermodal Surface Transportation Efficiency Act of 1991, 49 USC §14504, and Transportation Code, Chapter 645. A for-hire interstate carrier that is not registered under the single state registration system and is exempt from economic regulation by the Federal Motor Carrier Safety Administration under the Interstate Commerce Act shall register pursuant to Transportation Code, Chapter 643, and §18.13 of this subchapter.

(1) An interstate carrier must file with the department an application to register for all states of travel as required by 49 USC

§14504 before beginning operations in Texas if the carrier has its principal place of business:

(A) in Texas; or

(B) outside a participating state and selects Texas as its registration state under 49 CFR §367.3.

(2) An interstate carrier that is authorized by the Federal Motor Carrier Safety Administration to transport passengers or property and that must register in a state other than Texas must fully comply with 49 USC §14504 before operating in Texas.

(3) If an applicant's principal place of business is located outside a participating state, the applicant shall apply for registration in the state in which the applicant will operate the largest number of motor vehicles during the next registration year. The applicant may choose a registration state from participating states in which it will operate an equal number of vehicles if it will not operate a larger number in any other participating state.

(b) Initial application for single state registration. An application for single state registration must be made with the department's Motor Carrier Division on a form approved by the director. All information provided to the department must agree with information in the most recent Federal Motor Carrier Safety Administration certificate or permit issued to the applicant.

(1) Additional materials. An application must contain the following [~~be accompanied by~~]:

(A) information concerning all vehicles, whether owned or leased, that the applicant or registrant operates under Federal Motor Carrier Safety Administration (FMCSA) authority; [~~a copy of the applicant's full interstate authority, unless the department waives this requirement as described in paragraph (3) of this subsection;~~]

(B) a statement whether the applicant will be transporting hazardous commodities in interstate or foreign commerce; and [~~a copy of Federal Motor Carrier Safety Administration form BOC-3, prescribed by 49 CFR, Part 366;~~]

(C) applicable fees payable under subsection (i) of this section. [~~information on a form prescribed by the director of the Motor Carrier Division concerning all vehicles, whether owned or leased, that the applicant or registrant operates under Federal Motor Carrier Safety Administration authority;~~]

[~~(D) a statement whether the applicant will be transporting hazardous commodities in interstate or foreign commerce;~~]

[~~(E) applicable fees payable under subsection (i) of this section; and~~]

[~~(F) proof of insurance showing the applicant's business address as specified in subsection (j) of this section.~~]

(2) Requirements regarding principal place of business. An interstate carrier's principal place of business for registration is the business address the interstate carrier indicated on the order issued by the Federal Motor Carrier Safety Administration or the business address reported by the registrant to the Federal Motor Carrier Safety Administration as a change of address.

[~~(A)~~] The registrant must provide a physical address and may not provide only a post office box. The registrant may provide a second address, including a post office box, for use solely as a mailing address. An applicant domiciled in a rural area that does not have a street address may submit a rural route with a box number.

[~~(B) An applicant may change its registration state under subsection (e)(3) of this section.~~]

[~~(3) Waiver of filing complete Federal Motor Carrier Safety Administration authority. If the Federal Motor Carrier Safety Administration authority is longer than 20 pages, the department will waive the filing of the complete authority. In that case the applicant must:~~]

[~~(A) provide the department a copy of the portion of the Federal Motor Carrier Safety Administration order that includes the service date and order section; and~~]

[~~(B) file a prepared synopsis of the Federal Motor Carrier Safety Administration authority.~~]

(3) [~~(4)~~] Documents improperly filed. If an applicant files or causes to be filed any document that contains any misrepresentation, misstatement, or omission of required information or that does not include the payment of fees, the document will be deemed incomplete and will not be processed by the department until all items have been corrected.

(c) Registration issuance. The department will mail a registration receipt to an applicant that meets the requirements of this section and whose registration is approved. The registration receipt qualifies the registrant to operate under its Federal Motor Carrier Safety Administration certificate or permit in all jurisdictions indicated.

(d) Registration receipts. A registration receipt becomes effective on the date specified on the receipt and expires on the 31st day of December of the registration year for which it was issued. A registrant must retain its original registration receipt at its principal place of business for three years.

(1) Copies. A copy of the registration receipt, to be provided by the registrant, shall be carried in each motor vehicle for which the registrant has paid the applicable fees. On demand, the driver of a motor vehicle shall present a copy of a registration receipt for inspection by any department certified inspector in accordance with §18.31 of this chapter or any other authorized government personnel for inspection.

(2) Alterations of registration receipts. The department may revoke the registration of an interstate carrier that alters its registration receipt. Any law enforcement officer is authorized to confiscate the altered copy on sight. The confiscated registration receipt shall be returned to the department after any court action is completed by the state in which it was confiscated.

(3) Transfer of registration receipts between vehicles. A registration receipt may be transferred from a vehicle taken out of service to the registrant's replacement vehicle.

(4) Lost or stolen registration receipts. If the registrant fails to receive a receipt mailed by the department or if a registration receipt is otherwise lost, stolen, or destroyed, a registrant may request a replacement registration receipt, which will be provided without charge.

(e) Amendments and corrections after original registration.

(1) Any time a registrant is issued new FMCSA operating authority, order, or re-entitlement or if any amendments or revisions are made by the FMCSA to the registrant's authority and operations, the registrant must contact the department to request a new registration receipt. [~~Federal Motor Carrier Safety Administration amendments and revisions. A registrant shall file a supplemental application with the department if the registrant is issued new Federal Motor Carrier Safety Administration operating authority, order, or re-entitlement or if any amendments or revisions are made by the Federal Motor Carrier Safety Administration to the registrant's authority and operations. A copy of those documents shall be provided to the department as soon as they are issued.~~]

(2) Change of registrant name. If a registrant changes its name and a re-entitlement is issued by the FMCSA, the registrant must contact the department to request a new registration receipt. [If the registrant changes its name other than by transferring ownership, the registrant shall submit a request for a name change on a form prescribed by the director. The registrant shall submit to the department a copy of the re-entitlement issued by the Federal Motor Carrier Safety Administration. A registrant shall also furnish proof of insurance in the new name.]

(3) Change of registration state. A registrant's registration state may be changed only if the registrant changes its principal place of business or if its existing registration state ceases to participate in the single state registration system.

(A) If the registrant changes its principal place of business to a non-participating state, it shall retain the current registration state designation for registration purposes and file notice of a business address change in the form of a copy of a letter from the interstate carrier to the Federal Motor Carrier Safety Administration and shall also submit a new proof of insurance filing in its registration state.

(B) If a registrant changes its principal place of business to another participating state, the registrant shall:

(i) notify its current registration state and the new registration state within 30 days after making its selection;

(ii) notify its insurer immediately; and

(iii) file in the new registration state all the documents required of a new registrant.

(C) If a registrant changes its principal place of business during a registration period and that change affects its reciprocity status, the registrant will not be given a credit or refund for fees paid for that registration period. The current registration state will use the new principal place of business when determining fees for additional states of travel or equipment.

(4) Transfer of ownership. When Federal Motor Carrier Safety Administration authority is transferred to a new owner, the current registrant shall notify the department in writing to cancel its registration, and the new owner shall register with the department in accordance with this section.

(5) Other conditions requiring supplemental application. A supplemental application shall be filed if there is:

(A) an addition of equipment; or

(B) an addition of states of travel.[; or]

[(C) a change of designated process agent for any state.]

(6) Additional vehicles. A registrant may not operate more vehicles in any participating state than the number for which fees have been paid.

(7) Failure to update process agent. If a registrant fails to file [a supplemental application reflecting] a change in its process agent with the FMCSA, the department may suspend its registration under §18.72 of this chapter.

(f) Correction of application form. To correct an application form, an interstate carrier may notify the department in writing or correct the application returned by the department.

(g) Cancellation of registration. At the written request of a registrant, the department will cancel the interstate carrier's registration.

(h) Expiration and renewal of registration.

(1) Expiration. Registrations issued under this section are valid for the period beginning January 1 and ending December 31 or for any portion of that period. If registration is for a fraction of a year, the registration fee will not be pro-rated.

(2) Renewal. To renew an interstate carrier's registration, a registrant must follow the procedure outlined in subsection (b) of this section before December 1st of the existing registration period. The department will mail or send electronically a renewal notice to each registrant between August 1 and November 30 of the existing registration period. Failure to receive the notice does not relieve the registrant of the responsibility to renew.

[(A) To renew its registration, a registrant need not refile a full copy of its Federal Motor Carrier Safety Administration authority.]

[(B) An applicant must attach to its renewal application copies of additional authority grants, re-entitlements, transfer orders, or grants of self-insurance issued by the Federal Motor Carrier Safety Administration to the extent that those documents have not been previously filed with the department.]

[(3) Renewal fee. All renewal applications shall be accompanied by the appropriate fees as specified in department Form RS-2.]

(i) Payment of Fees.

(1) Fees must be paid as specified in §18.15 of this subchapter.

(2) If an applicant has evidence that any fees collected or charged on or before November 15, 1991, were different from the fees specified in the department's Form RS-1A, the applicant shall submit the evidence to the department with the application. After considering the submission, the department will notify the applicant or registrant if the proper fee has not been paid. Each participating state, in computing the appropriate portion of the revenue due the department for its registrants, may use the department's Form RS-2 to determine the registrant's per-vehicle fee.

(j) Insurance requirements. The applicant must ensure that proof of insurance is filed with the FMCSA [department]. Proof of insurance must be in accordance with the levels and forms specified by 49 CFR, Part 387, Subpart C. [In all applications, the interstate carrier shall indicate whether proof of insurance will be filed or has been filed with the department and whether the interstate carrier's public liability protection remains effective.] A copy of the applicant's public liability policy with the endorsements attached shall be maintained at the interstate carrier's principal place of business.

(1) Registrant name. Proof of insurance shall be filed in the full and correct name of the person to whom the certificate or permit is issued. The registrant's full name must include, all owner names and any fictitious name or d/b/a. The name and business address on the proof of insurance must be identical to the name and business address contained in its application and in its most recent Federal Motor Carrier Safety Administration order.

(2) Form of proof. Proof of insurance shall be filed as specified by 49 CFR, Part 387, Subpart C. A "certificate of insurance" issued by an insurance agent will not be accepted as proof of insurance.

(3) Self insurers. If an applicant has been approved for self-insurance by the Federal Motor Carrier Safety Administration, the applicant must indicate the status of such self-insurance on the application form. The applicant must also file with the department a copy of the Federal Motor Carrier Safety Administration order approving a public liability self-insurance or other public liability security or agreement under the provisions of 49 CFR, Part 387, Subpart C. The regis-

trant shall immediately notify the department if the self-insurance plan is suspended, revoked, or modified by a Federal Motor Carrier Safety Administration order. Failure to comply may result in the suspension of the registration.

(4) Changes in status. A registrant shall immediately notify the department of all changes in the status of the registrant's public liability protection.

(5) Incorrect or falsified proof of insurance. If an insurance company notifies the department that information relating to a registrant's proof of insurance is incorrect or has been falsified, the department may verify the insurance information of the insured.

(A) If the department finds that incorrect or falsified filings have been made, the department will notify the registrant immediately and request new proof of insurance.

(B) If new and valid proof of insurance is not received, the department may initiate a proceeding for suspension or revocation of a registration, assessment of an administrative penalty, or both.

(6) Cancellation of insurance. On receiving notice of cancellation of a registrant's proof of insurance, the department will notify the registrant in writing that its registration to operate in all states of travel is suspended on the effective date of the cancellation of the insurance as specified in 49 CFR §387.317. [~~The effective date of the cancellation notice for proof of insurance will be computed as 30 days from the date notice is received by the department. An insurer may not terminate coverage until at least 30 days after the department has received notice of the cancellation.~~]

(A) If insurance lapses because a proof of insurance has not been filed with the correct name and business address, the interstate carrier's registration will be suspended until proper proof of insurance is filed with the department.

(B) When sufficient proof of insurance or other proof of compliance is filed and in effect after a suspension of the registration, the department will immediately reinstate the interstate carrier's registration and notify the registrant that its registration is restored.

[~~(k) Electronic filings. The department may elect to receive or verify electronic filings of proof of insurance.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505335
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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43 TAC §18.18

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.18. Temporary Registration of International Motor Carriers.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505336
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

♦ ♦ ♦

SUBCHAPTER C. RECORDS AND INSPECTIONS

43 TAC §18.32

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.32. Motor Carrier Records.

(a) General records to be maintained. Every motor carrier shall prepare and maintain at its principal place of business in Texas:

(1) operational logs, insurance certificates, and documents to verify the carrier's operations;

(2) complete and accurate records of services performed;

(3) all certificate of title documents, weight tickets, permits for oversize or overweight vehicles and loads, dispatch records, tow tickets, or any other document that would verify the operations of the vehicle to determine the actual weight, insurance coverage, size, and/or capacity of the vehicle;

(4) documents supporting fee payments and the original registration receipts issued by the department for an interstate carrier registered under §18.17 of this chapter (relating to Single State Registration System), for a period of at least three years; and

(5) the original certificate of registration and registration listing, if applicable.

(b) Additional records for household goods carriers. In order to verify compliance with Subchapters B and E of this chapter, every household goods carrier shall retain complete and accurate records maintained in accordance with reasonable accounting procedures of all services performed in intrastate commerce. Household goods carriers shall retain all of the following information and documents:

(1) moving services contracts, such as, bills of lading or receipts;

(2) proposals for moving services;

(3) inventories, if applicable;

(4) freight bills;

(5) time cards, trip sheets, or driver's logs;

(6) claim records;

(7) ledgers and journals;

(8) canceled checks;

(9) bank statements and deposit slips;

(10) invoices, vouchers or statements supporting disbursements; and

(11) dispatch records.

(c) Proof of motor carrier registration. [~~Except as provided in paragraphs (1) and (2) of this subsection,~~]

(1) Every [~~every~~] motor carrier shall maintain a copy of its current registration listing in the cab of each registered vehicle at all times. A motor carrier shall make available to a certified inspector or any law enforcement officer a copy of the current registration listing upon request.

[~~(1) A Type B household goods carrier shall maintain a copy of its certificate of registration in either the cab of each power unit or each trailer operated on its behalf at all times. A Type B household goods carrier shall make available and accessible to a certified inspector or any law enforcement officer a copy of the current certificate of registration.~~]

(2) A registered motor carrier is not required to carry proof of registration in a vehicle leased from a leasing business that is registered under §18.19 of this chapter (relating to Short-term Lease and Substitute Vehicles), when leased as a temporary replacement due to maintenance, repair, or other unavailability of the originally leased vehicle. A copy of the lease agreement, or the lease for the originally leased vehicle, in the case of a substitute vehicle, must be carried in the cab of the vehicle.

(d) Location of files. Except as provided in paragraphs (1) and (2) of this subsection, every motor carrier shall maintain at a principal office in Texas all records and information required by the department.

(1) Texas firms. If a motor carrier wishes to maintain records at a location other than its principal office in Texas, the motor carrier shall make a written request to the manager. A motor carrier may not begin maintaining records at an alternate location until the request is approved by the manager.

(2) Out-of-state firms. A motor carrier whose principal business address is located outside the state of Texas shall maintain records required under this section at its principal office in Texas. Alternatively, a motor carrier may maintain such records at an out-of-state facility if the carrier reimburses the department for necessary travel expenses and per diem for any inspections or investigations conducted in accordance with §18.31 of this subchapter.

(3) A motor carrier that performs nonconsent tows shall maintain a current towing fee schedule, as prescribed in Subchapter H of this chapter (relating to Nonconsent Towing Fees Schedule), at all vehicle storage facilities where vehicles are delivered.

(e) Preservation and destruction of records. All books and records generated by a motor carrier, except driver's time cards and logs, must be maintained for not less than two years at the motor carrier's principal business address. A motor carrier must maintain driver's time cards and logs for not less than six months at the carrier's principal business address.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

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Richard D. Monroe
General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-8630

SUBCHAPTER E. CONSUMER PROTECTION

43 TAC §§18.51, 18.58, 18.63 - 18.65

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.51. Household Goods Agents.

(a) Appointment of household goods agent. A household goods carrier may appoint a household goods agent to represent the household goods carrier's business interests in Texas.

(b) Liability. A household goods carrier is responsible for the acts, delinquencies, omissions, and conduct of each of its household goods agents while acting on behalf of the household goods carrier.

(c) Agent filing. A household goods carrier shall file with the department, on a form approved by the director, a current, accurate list of its household goods agents and their addresses.

(1) A household goods carrier using alternative vehicle registration under §18.13(e) of this title (relating to Application for Motor Carrier Registration) shall notify the department 30 days prior to the creation or termination of an agency agreement.

(2) A household goods carrier not using the alternative vehicle registration shall notify the department on or before January 1, April 1, July 1, and October 1, of each year of the creation or termination of an agency agreement.

(d) Use of household goods carrier's name. When representing a household goods carrier, the agent:

(1) shall operate under the name of the represented household goods carrier, as shown on the certificate of registration issued by the department;

(2) shall use only the moving services contract of the represented household goods carrier; and

(3) may include its name, as listed on the household goods carrier's agent filing, on the carrier's advertisements.

(e) Availability of tariff records. A [~~Type A~~] household goods carrier shall require each of its household goods agents to keep copies of the applicable tariff in the household goods agent's office and open to public inspection.

(f) Shipping records maintained. A household goods agent shall keep a record of every shipment that it sells or handles for at least two years after the date of shipment.

(g) Agency agreements. An agreement between a household goods carrier and its household goods agent shall be in writing and signed by the household goods carrier and the household goods agent, and copies of any agreement must be kept in the files of the household goods carrier for a period of not less than two years following the date of termination of each agreement.

§18.58. Moving Services Contract - Options for Carrier Limitation of Liability.

(a) General.

(1) Household goods shipments transported between points in Texas shall be subject to all terms and conditions of the moving services contract, as set forth in §18.57 of this title (relating to Moving Services Contract), except in cases where such terms and conditions are in conflict with the laws of the State of Texas.

(2) If a household goods carrier chooses to use additional limitations of liability on a shipment, the limitations shall be either of the options specified in subsections (b) or (c) of this section. A household goods carrier may not alter or expand on the limitation to its liability or the exact wording set out in subsections (b) or (c) of this section. The option selected by the household goods carrier shall be included with and is part of the moving services contract.

(b) Option 1. If this option is chosen, the following language must be used verbatim.

(1) Section 1 - General Provisions.

(A) For the purposes of this subsection, the following terms will mean:

(i) Household goods carrier - the motor carrier/mover contracted to transport a shipment of household goods.

(ii) Shipper - the owner of the household goods shipment or his representative.

(B) Changes to the moving service contract are not valid unless agreed to in writing by the household goods carrier and the shipper.

(C) Household goods carriers will transport shipments with reasonable dispatch. Reasonable dispatch requires the transportation of a shipment within the agreed period of time shown on the moving services contract, except when circumstances beyond the carrier's control, force majeure, prevent or delay transportation.

(D) Moving services contracts must comply with all other applicable laws of the State of Texas.

(2) Section 2 - Cargo Liability Provisions.

(A) The household goods carrier is liable for any loss or damage to the shipment, except as listed in subparagraphs (B) and (C) of this paragraph.

(B) The household goods carrier is not responsible for loss, damage, or delay due to acts of God, acts of civil authorities, defects in the shipment, a riot, a strike, or an act or default of the shipper.

(C) The household goods carrier is not liable for loss or damage caused by dangerous or explosive goods unless the shipper notifies the carrier, in writing, of the nature of the goods and the carrier agrees, in writing, to the transportation of these goods.

(3) Section 3 - Claims Provisions.

(A) A written claim must be filed by the shipper within 90 days of delivery of the shipment to the final destination. In case of failure to make delivery, then a written claim must be filed by the shipper within 90 days after a reasonable time for delivery has elapsed.

(B) A household goods carrier is not liable for any claim that is not filed within 90 days of the delivery of the shipment to the final destination. A household goods carrier is not liable for any claim that is not filed within 90 days after a reasonable time for delivery has elapsed for shipments that were not delivered.

(4) Section 4 - Payment Provisions. The shipper must pay the freight charges upon delivery unless the shipper and household goods carrier agree otherwise.

(5) Section 5 - Provisions for Shipments Not Delivered.

(A) A household goods carrier may place a shipment of household goods into storage if the shipper is not available for delivery of the goods as scheduled.

(B) The cost of such storage is the responsibility of the shipper of the household goods.

(C) A shipment of household goods placed in storage is subject to liens for storage, freight, and other lawful charges.

(D) A household goods carrier must issue written notice of the storage of the household goods to the shipper at each address shown on the moving services contract within three days of placing the goods in storage.

(E) If the shipper refuses to accept or does not claim the household goods within 15 days of the written notice of storage, the household goods carrier may begin the process of selling the goods at public sale, as prescribed in Transportation Code, Chapter 6.

(F) A household goods carrier must give written notice of the public sale to the shipper at each address shown on the moving services contract.

(G) The moving services contract does not prohibit the sale of the goods under any other lawful manner if the method set out in the contract cannot be reasonably accomplished.

(c) Option 2. If this option is chosen, the following language must be used verbatim.

(1) Section 1 of contract terms and conditions.

(A) The household goods carrier or party in possession of any of the property herein described shall be liable at common law for any loss thereof or damage thereto, except as hereinafter provided.

(B) No household goods carrier or party in possession of all or any of the property herein described shall be liable for any loss thereof or damage thereto or delay caused by an act of God, the public enemy, the authority of law, or an act or default of the shipper or owner. The household goods carrier's liability shall be that of warehouseman only, for loss, damage, or delay caused by fire occurring after the expiration of the free time (if any) allowed by tariffs lawfully on file after notice of the arrival of the property at destination has been duly sent or given, and after placement of the property for delivery at destination, or tender of delivery of the property to the party entitled to receive it, has been made. Except in case of negligence of the household goods carrier or party in possession (and the burden to prove freedom from such negligence shall be on the household goods carrier or party in possession), the household goods carrier or party in possession shall not be liable for loss, damage, or delay occurring while the property is stopped and held in transit upon the request of the shipper, owner, or party entitled to make such request, or resulting from a defect or inherent vice of the article, including susceptibility to damage because of atmospheric conditions such as temperature and humidity or changes therein [~~in the property~~], or from riots or strikes. Except in the case of household goods carrier's negligence, no household goods carrier, or party in possession of all or any of the property herein described, shall be liable for delay caused by highway obstruction, faulty or impassable highway, or lack of capacity of any highway, bridge, or ferry, and the burden to prove freedom from such negligence shall be on the household goods carrier or party in possession.

(C) In case of quarantine the property may be discharged at the risk and expense of the owner into quarantine depot or elsewhere, as required by quarantine regulations or authorities, or for the household goods carrier's dispatch at the nearest available point in the household goods carrier's judgment, and in any such case the household goods carrier's responsibility shall cease when property is so discharged, or property may be returned by the household goods carrier at the owner's expense to the shipping point, earning freight both ways. Quarantine expenses of whatever nature or kind upon or in respect to property shall be borne by the owner of the property or the household goods carrier may file a lien. The household goods carrier shall not be liable for loss or damage occasioned by fumigation or disinfection or other acts required or done by quarantine regulations or authorities even though the same may have been done by the household goods carrier's officers, local agents, or employees, nor for detention, loss, or damage of any kind occasioned by the quarantine or its enforcement. A household goods carrier shall not be liable, except in the case of negligence, for any mistake or inaccuracy in any information furnished by the household goods carrier, its local agents, or officers, as to quarantine laws or regulations. The shipper shall hold the household goods carrier harmless from any expense it may incur, or damages it may be required to pay, by reason of the introduction of the property covered by this contract into any place against the quarantine laws or regulations in effect at such place.

(2) Section 2 of contract terms and conditions.

(A) A household goods carrier is not bound to transport property by any particular scheduled vehicle or in time for any particular market other than with reasonable dispatch. A household goods carrier shall have the right, in case of physical necessity, to forward the property by any household goods carrier or route between the point of shipment and the point of destination. In all cases not prohibited by law, where a lower value than actual value has been represented in writing by the shipper or has been agreed upon in writing as the released value of the property as determined by the classification or tariffs upon which the rate is based, such lower value plus freight charges, if paid, shall be the maximum amount recovered, whether or not such loss or damage occurs from negligence.

(B) As a condition precedent to recovery, a claim must be filed in writing with the receiving or delivering household goods carrier, or the household goods carrier issuing the bill of lading or receipt, or the household goods carrier on whose line the loss, damage, injury, or delay occurred, or the household goods carrier in possession of the property when the loss, damage, injury, or delay occurred, within 90 days after delivery of the property or, in case of failure to make delivery, then within 90 days after a reasonable time for delivery has elapsed; and suits shall be instituted against any household goods carrier only within two years and one day from the day when notice in writing is given by the household goods carrier to the claimant that the household goods carrier has disallowed the claim or any of its part or parts specified in the notice. Where a claim is not filed or a suit is not instituted in accordance with the foregoing provisions, a household goods carrier hereunder shall not be held liable, and the claim will not be paid.

(C) Any household goods carrier or party liable on account of loss of or damage to any of the property shall have the full benefit of any insurance that may have been effected, upon, or on account of, said property, so far as this shall not avoid the policies or contracts of insurance; provided, that the household goods carrier reimburses the claimant for the premium paid.

(3) Section 3 of contract terms and conditions. Except where such service is required as the result of household goods carrier's negligence, all property shall be subject to necessary cooperage and baling at the owner's cost.

(4) Section 4 of contract terms and conditions.

(A) Property not removed by the party entitled to receive it within the free time (if any) allowed by tariff lawfully on file (such free time to be computed as therein provided), after notice of the arrival of the property at destination has been duly sent or given, and after tender of the property for delivery at destination has been made, or property not received, at time tender of delivery of the property to the party entitled to receive it has been made, may be kept in vehicle, warehouse, or place of business of the household goods carrier, subject to the tariff charge for storage and to household goods carrier's responsibility as warehouseman, only, or at the option of the household goods carrier, may be removed to and stored in a public or licensed warehouse at the point of delivery or other available point, or if no such warehouse is available at point of delivery or at other available storage facility, at the cost of the owner and there held without liability on the part of the household goods carrier, and subject to a lien for all freight and other lawful charges, including a reasonable charge for storage. In the event consignee cannot be found at address given for delivery, notice of the placing of such goods in warehouse shall be mailed to the address given for delivery and mailed to any other address given on the bill of lading or receipt for notification, showing the warehouse in which the property has been placed.

(B) If nonperishable property which has been transported to destination hereunder is refused by consignee or the party

entitled to receive it upon tender of delivery, or said consignee or party entitled to receive it fails to receive or claim it within 15 days after notice of arrival shall have been duly sent or given, the household goods carrier may sell the same at public auction to the highest bidder, at such place as may be designated by the household goods carrier; provided, that the household goods carrier shall have first mailed, sent, or given to the consignor notice that the property has been refused or remains unclaimed, as the case may be, and that it will be subject to sale under the terms of the bill of lading or receipt if disposition be not arranged for, and shall have published notice containing a description of the property, the name of the party to whom consigned, or, if shipped order notify, the name of party to be notified, and the time and place of sale, once a week for two successive weeks, in a newspaper of general circulation at the place of sale or nearest place where such newspaper is published. Thirty days must elapse after notice that the property was refused or remains unclaimed was mailed, sent, or given before notice of sale may be published.

(C) If perishable property which has been transported is refused by the consignee or party entitled to receive it, or the consignee or party entitled to receive it shall fail to receive it promptly, the household goods carrier may, in its discretion, to prevent deterioration or further deteriorations, sell the same to the best advantage at private or public sale; provided, that if time serves for notification to the consignor or owner of the refusal of the property or the failure to receive it and request for disposition of the property, notification shall be given, in such manner as the exercise of due diligence requires before the property is sold.

(D) If the procedure provided for in this section is not possible, it is agreed that nothing contained in the section shall be construed to abridge the right of the household goods carrier at its option to sell the property under such circumstances and in such manner as may be authorized by law.

(E) The proceeds of the sale shall be applied by the household goods carrier to the payment of freight, demurrage, storage, and any other lawful charges and the expense of notice, advertisement, sale, and other necessary expense and of caring for and maintaining the property, if proper care requires special expense. If there is a balance it shall be paid to the owner of the property.

(F) If the household goods carrier is directed by the consignor or its agent to load property from (or render any services at) a place or places at which the consignor or its agent is not present, the property shall be at the risk of the owner before loading.

(G) If the household goods carrier is directed by the consignee or its agent to unload or deliver property (or render any services) at the place or places at which the consignee or its agent is not present, the property shall be at the risk of the owner after unloading or delivery.

(5) Section 5 of contract terms and conditions. A household goods carrier shall not carry or be liable in any way for documents, specie, or for articles of extraordinary value not specifically rated in the published classification or tariffs unless a special agreement to do so and a stipulated value of the articles are endorsed.

(6) Section 6 of contract terms and conditions. Every party, whether the principal or local agent, shipping explosives or dangerous goods, without previous full written disclosure to the household goods carrier of their nature, shall be liable for and indemnify the household goods carrier against all loss or damage caused by the goods, and the goods may be warehoused at the owner's risk and expense or destroyed without compensation.

(7) Section 7 of contract terms and conditions.

(A) The owner or consignee shall pay the freight and all other lawful charges accruing on said property; but, except in those instances where it may lawfully be authorized to do so, no household goods carrier shall deliver or relinquish possession at destination of the property covered by this bill of lading or receipt until all rates and charges have been paid. The consignor shall be liable for the freight and all other lawful charges, except that if the consignor stipulates, by signature, in the space provided for that purpose on the face of this bill of lading or receipt that the household goods carrier shall not make delivery without requiring payment of the charges and the household goods carrier, contrary to such stipulation shall make delivery without requiring such payment, the consignor (except as hereinafter provided) shall not be liable for the charges. Where the household goods carrier has been instructed by the shipper or consignor to deliver the property to a consignee other than the shipper or consignor, the consignee shall not be legally liable for transportation charges in respect of the transportation of the property (beyond those billed against him at the time of delivery for which he is otherwise liable) which may be found to be due after the property has been delivered to him, if the consignee is an agent only and has no beneficial title in said property, and prior to delivery of said property has notified the delivering household goods carrier in writing of the fact of such agency and absence of beneficial title, and, in the case of a shipment reconsigned or diverted to a point other than that specified in the original bill of lading or receipt, has also notified the delivering household goods carrier in writing of the name and address of the beneficial owner of said property; and, in such cases the shipper or consignor, or, in the case of a shipment so reconsigned or diverted, the beneficial owner shall be liable for such additional charges.

(B) If the consignee has given to the household goods carrier erroneous information as to whom the beneficial owner is, such consignee shall be liable for the additional charges. Nothing herein shall limit the right of the household goods carrier to require at time of shipment the payment or guarantee of the charges. If upon inspection it is ascertained that the articles shipped are not those described in this bill of lading or receipt, the freight charges must be paid on the articles actually shipped.

(8) Section 8 of contract terms and conditions. If this bill of lading or receipt is issued on the order of the shipper or his agent, in exchange or in substitution for another bill of lading or receipt, the shipper's signature to the prior bill of lading or receipt as to the statement of value or otherwise, or election of common law or bill of lading or receipt, in or in connection with such prior bill of lading or receipt, shall be considered a part of this bill of lading or receipt as fully as if the same were written or made in or in connection with this bill of lading or receipt.

(9) Section 9 of contract terms and conditions. Any alteration, addition, or erasure in this bill of lading or receipt which shall be made without the special notation herein of the agent of the household goods carrier issuing this bill of lading or receipt, shall be without effect, and this bill of lading or receipt shall be enforceable according to its original tenor.

§18.63. Annual Report.

(a) Submission date. On or before the 15th day of May of each year, every household goods carrier shall file a copy of its annual operating report (on a form approved by the director) with the department. [~~Type B household goods carriers shall file their first annual operating report on or before May 15, 1999 and then every subsequent year on or before May 15th.~~]

(b) Contents. Annual reports shall include, at a minimum, the following information on intrastate household goods shipments:

(1) the total number of shipments;

(2) the total number of claims that resulted in mediations coordinated by the department; and

(3) the total number of claims resolved after a lawsuit was filed.

§18.64. Rates.

[~~(a) Applicability. This section applies only to Type A household goods carriers.~~]

(a) [~~(b)~~] Ratemaking. A household goods carrier and/or its household goods agent shall set maximum rates and charges for services in its applicable tariff. The household goods carrier and/or its household goods agent shall disclose the maximum rates and charges to prospective shippers before transporting a shipment between two incorporated cities.

(b) [~~(c)~~] Prohibited charges and allowances. A household goods carrier and/or its household goods agent shall not charge more than the maximum charges published in its tariff on file with the department for services associated with transportation between two incorporated cities.

(c) [~~(d)~~] Collective ratemaking agreements.

(1) Eligibility. In accordance with Transportation Code, §643.154, a household goods carrier and/or its household goods agent may enter into collective ratemaking agreements between one or more other household goods carriers or household goods agents concerning the establishment and filing of maximum rates and charges, classifications, rules, or procedures.

(2) Designation of collective ratemaking associations. An approved association may be designated by a member household goods carrier as its collective ratemaking association for the purpose of filing a tariff containing maximum rates and charges required by §18.65 of this title (relating to Tariff Registration).

(3) Submission. In accordance with Transportation Code, §643.154, a collective ratemaking agreement shall be filed with the department for approval. The agreement shall include the following information:

(A) full and correct name, business address (street and number, city, state and zip code), and phone number of the association;

(B) whether the association is a corporation or partnership; and

(i) if a corporation, the government, state, or territory under the laws of which the applicant was organized and received its present charter; and

(ii) if an association or a partnership, the names of the officers or partners and date of formation;

(C) full and correct name and business address (city and state) of each household goods carrier on whose behalf the agreement is filed and whether it is an association, a corporation, an individual, or a partnership;

(D) the name, title, and mailing address of counsel, officer, or other person to whom correspondence in regard to the agreement should be addressed; and

(E) a copy of the constitution, bylaws, or other documents or writings, specifying the organization's powers, duties, and procedures.

(4) Signature. The collective ratemaking agreement shall be signed by all parties subject to the agreement or the association's executive officer.

(5) Incomplete agreement. If the department receives an agreement which does not comply with this subsection, the department will send a letter to the individual submitting the agreement. The letter shall identify the information that is missing and advise the association that the agreement will not be processed until the information is received.

(6) Approval. In accordance with Transportation Code, §643.154, the director or designee will approve a collective ratemaking agreement if the agreement provides that:

(A) all meetings are open to the public; and

(B) notice of meetings shall be sent to shippers who are multiple users of household good carriers.

(7) Noncompliance.

(A) If the director or designee determines that an agreement does not comply with paragraph (6) of this subsection, the department will notify the association representative by certified mail of:

(i) the specific reason that an agreement is not being approved; and

(ii) the hearing date.

(B) If the association representative resubmits an acceptable agreement which meets the requirements of paragraph (6) of this subsection within 10 business days prior to the hearing date, the hearing will be canceled and the agreement will be approved. The State Office of Administrative Hearings (SOAH) shall conduct the hearing in accordance with 43 TAC §1.21 et seq. of this title (relating to Contested Case Procedure).

(C) If the hearing is held, the presiding officer shall explain the reason(s) that the agreement was rejected. The association representative will be allowed to respond to the objections and present evidence or exhibits which relate to his or her response. The hearing examiner, based on the evidence provided, will make a recommendation to the commission whether the agreement should be approved or resubmitted. The association representative shall be advised of the examiner's recommendation. The final order will be submitted to the commission for approval.

(8) New parties to an agreement. An updated agreement shall be filed with the department as new parties are added.

(9) Amendments to approved agreements. Amendments to approved agreements (other than as to new parties) may become effective only after approval of the department.

§18.65. Tariff Registration.

[~~(a) Applicability. This section only applies to Type A household goods carriers.~~]

(a) [~~(b)~~] Submission. In accordance with Transportation Code, §643.153, a household goods carrier and/or its household goods agent shall file a tariff with the department. The tariff shall establish maximum rates and charges for transportation services when a highway between two or more municipalities [~~incorporated cities, towns or villages~~] is traversed. A household goods carrier who is not a member of an approved association under §18.64 of this title (relating to Rates) shall file a tariff individually. In lieu of filing individually, a household goods carrier or its household goods agent, that is a member of an approved association in accordance with §18.64 of this title (relating to Rates), may designate a collective association as its ratemaking association. The association may file a tariff, as required by this subsection, for member carriers.

(1) Contents. The tariff:

(A) shall set out all rates, charges, rules, regulations, or other provisions, in clear and concise terms, used to determine total transportation charges;

(B) may provide for the offering, selling, or procuring of insurance as provided in §18.54 of this title (relating to Selling Insurance to Shippers);

(C) may provide for the base transportation charge to include assumption by the household goods carrier for the full value of the shipment in the event a policy or other appropriate evidence of the insurance purchased by the shipper from the household goods carrier is not issued to the shipper at the time of purchase;

(D) shall describe the procedure for determining charges that are below the maximum rate for each service performed; and

(E) shall reference a specific mileage guide or source, if information on rates and charges based on mileage is included in the tariff (The referenced mileage guide shall be filed with the department as an addendum to the tariff. If the household goods carrier utilizes a computer database as a mileage guide, the household goods carrier shall allow department personnel free access to the system when conducting an inquiry regarding a specific movement performed by the household goods carrier).

(2) Interstate tariff. In accordance with Transportation Code, §643.153, a household goods carrier may satisfy the requirements of this subsection by filing a copy of its tariff governing interstate household goods transportation services.

(3) Transmittal letter. A transmittal letter shall accompany a tariff being filed. The transmittal letter shall provide:

(A) the name of the household goods carrier;

(B) the Texas mailing address and street address of the household goods carrier's principal office;

(C) the household goods carrier's registration number;

(D) the name and title of the household goods carrier's representative authorizing the tariff filing; and

(E) whether the tariff is being filed on behalf of a member carrier.

(4) Format. Tariffs shall be filed:

(A) on 8 1/2" x 11" paper;

(B) with a cover sheet showing:

(i) the name of the issuing household goods carrier or collective ratemaking association;

(ii) the Texas mailing and street address;

(iii) the issuance date of the tariff;

(iv) the effective date of the tariff; and

(v) the tariff number; and

(C) separated into the following sections:

(i) general rules;

(ii) accessorial services; and

(iii) rates.

(5) Item numbers. Individual items shall be titled and designated by item number.

(6) Amendments. Any amendment to a tariff shall be filed with the department not less than 10 days prior to the effective date of the amendment. The household goods carrier or collective ratemaking association filing on behalf of its member may either file an amended tariff in total or an amendment referencing the specific sections and items which are being amended. The amendment format shall be the same as required by paragraph (4) of this subsection. A transmittal letter providing the same information as required by paragraph (3) of this subsection shall accompany the amendment filing.

(7) Rejection. The department will reject a tariff or amendment filing if it is determined the tariff:

(A) fails to meet the requirements of this section; or

(B) fails to fully disclose, in clear and concise terms, all rates, charges, and rules.

(8) Electronic filings. A household goods carrier may file an electronic copy of its tariff provided that the document is consistent with the provision of this subsection and is formatted in Microsoft Word or other format approved by the director.

(b) [~~(c)~~] Operations. The department will accept a tariff which is in substantial compliance with this section if the tariff was submitted prior to November 1, 1995.

(c) [~~(d)~~] Access. In accordance with Transportation Code, §643.153, tariffs filed in accordance with this section will be made available for public inspection at the Motor Carrier Division, 4203 Bull Creek Road, Building 22, Austin, Texas, 78731, and by calling 1-800-299-1700.

(d) [~~(e)~~] Conflicts. All provisions of household goods carriers' tariffs are superseded to the extent they may conflict with the provisions of this chapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

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Richard D. Monroe
General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-8630

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SUBCHAPTER G. VEHICLE STORAGE FACILITIES

43 TAC §§18.82, 18.87 - 18.93, 18.96

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §643.003, which allows the department to adopt rules to administer Chapter 643 regarding motor carrier registration; and Occupations Code, §2303.051, which provides the commission with the authority to establish rules regarding vehicle storage facilities.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 643, and Occupations Code, Chapter 2303

§18.82. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Vehicle Storage Facility Act, Occupations Code, Chapter 2303, concerning vehicle storage facilities.

(2) Abandoned nuisance vehicle--A motor vehicle that is at least 10 years old and is of a condition only to be demolished, wrecked, or dismantled.

(3) Affidavit of Right of Possession and Control--A form prescribed by the department and provided by the licensee for use by an individual certifying right of possession if the licensee is unable to verify the individual's status as an immediate family member.

(4) Day--Twenty-four continuous hours.

(5) Fence--An enclosure of wood, chain link, iron, concrete, or masonry, placed around an area used to store vehicles and designed to prevent intrusion and escape.

(6) Immediate family--An individual's parents, spouse, children, brothers, and sisters if they reside in and are supported by the same household.

(7) Impoundment--The following actions when performed on a stored vehicle:

(A) using materials such as plastic or canvas tarpaulins to ensure the preservation of a stored vehicle if doors, windows, convertible tops, hatchbacks, sun roofs, trunks, or hoods are broken or inoperative;

(B) conducting a written inventory of any unsecured personal property contained in a stored vehicle;

(C) removing and storing all unsecured personal property that is contained in a stored vehicle and for which safekeeping is necessary; and

(D) obtaining motor vehicle registration information for a specific vehicle directly or indirectly from the department's Vehicle Titles and Registration Division.

(8) Main entrance--The initial point from the public road onto the private property leading to the vehicle storage facility at which a consumer or service recipient enters a vehicle storage facility.

(9) Person--An individual, corporation, organization, business trust, estate, trust, partnership, association, or other legal entity.

(10) Principal--An individual who:

(A) holds, whether personally, as a beneficiary of a trust, or by other constructive means:

(i) 10% of a corporation's outstanding stock; or

(ii) an ownership interest in a business that is equivalent to a fair market value of more than $25,000;

(B) has the controlling interest in a business;

(C) has a participating interest of more than 10% in the profits, proceeds, or capital gains of a business, regardless of whether the interest is direct or indirect, whether it is held through share, stock, or any other manner, or whether it includes voting rights;

(D) holds a position as a member of the board of directors or other governing body of a business; or

(E) holds a position as an elected officer of a business.

(11) Registered owner--Each person in whose name a vehicle is titled under Transportation Code, Chapter 501, or in whose name a vehicle is registered under Transportation Code, Chapter 502.

(12) Vehicle--A motor vehicle subject to registration under Transportation Code, Title 7, Subtitle A, or any other device designed to be self-propelled or transported on a public highway.

(13) Vehicle owner--A person:

(A) in whose name a vehicle is registered under the Certificate of Title Act, Transportation Code, Chapter 501;

(B) in whose name a vehicle is registered under Transportation Code, Chapter 502, or a member of that person's immediate family;

(C) who holds a vehicle through a valid lease agreement;

(D) who is an unrecorded lienholder with a right to possession; or

(E) who is a lienholder that holds an affidavit of repossession and has the right to repossess a vehicle.

(14) Vehicle storage facility (VSF)--A garage, parking lot, or other facility owned or operated by a person other than a governmental entity for storing or parking 10 or more vehicles per year.

(15) Vehicle transfer--Any movement of a vehicle out of a VSF, prior to its release as prescribed in §18.92(a) of this chapter (relating to Technical Requirements).

§18.87. Notifications Regarding Towed Vehicles.

(a) Applicability. If a vehicle is removed by the vehicle owner within 24 hours after the operator receives the vehicle, notification as described in subsections (b) - (d) of this section does not apply.

(b) Notification to owners of registered vehicles. Registered owners of towed vehicles shall be notified in the following manner.

(1) Vehicles registered in Texas. After accepting for storage a vehicle registered in Texas, the VSF shall notify the vehicle's current registered owner and all recorded lienholders by certified, electronic certified, or registered mail within five days, but in no event sooner than within 24 hours of receipt of the vehicle.

(2) Vehicles not registered in [~~outside of~~] Texas. After accepting for storage a vehicle not registered in [~~outside of~~] Texas, the VSF shall notify the vehicle's current registered owner and all recorded lienholders within 14 days, but in no event sooner than within 24 hours of receipt of the vehicle, by:

(A) certified, electronic certified mail, or registered mail; or

(B) notice by publication in a newspaper of general circulation in the county in which the vehicle is stored if:

(i) the vehicle is registered in another state;

(ii) the operator of the storage facility submits a written request that is correctly addressed, with sufficient postage, and is sent by certified mail, or electronic certified mail, return receipt requested, to the governmental entity with which the vehicle is registered requesting information relating to the identity of the last known registered owner and any lienholder of record;

(iii) the identity of the last known registered owner cannot be determined;

(iv) the registration does not contain an address for the last known registered owner; [~~and~~]

(v) the operator of the storage facility cannot reasonably determine the identity and address of each lienholder; or,[~~.~~]

(vi) the vehicle does not display a license plate or a vehicle inspection certificate indicating the state of registration and the identity and address of the registered owner and lienholder cannot be reasonably determined by the operator of the storage facility.

(3) It is a defense to an action initiated by the department for violation of this section that the facility has attempted unsuccessfully and in writing to obtain information from the governmental entity with which the vehicle is registered.

(c) Date of notification. Notification will be considered to have occurred when the United States Postal Service places its postmark on the written notice or on the date of newspaper publication of the notice.

(d) Form of notifications. All mailed notifications must be correctly addressed and mailed with sufficient postage. Notices published in a newspaper may contain information for more than one vehicle.

(1) All mailed notifications shall state:

(A) the full licensed name of the VSF where the motor vehicle is located, its street address and telephone number, and the hours the vehicle can be released to the vehicle owner;

(B) the daily storage rate, the type and amount of all other charges assessed, and the statement, "Total storage charges cannot be computed until vehicle is claimed. The storage charge will accrue daily until vehicle is released";

(C) the date the vehicle will be transferred from the VSF and the address to which the vehicle will be transferred if the operator will be transferring a vehicle to a second lot because the vehicle has not been claimed within a certain time;

(D) the date the vehicle was accepted for storage and from where, when, and by whom the vehicle was towed;

(E) the VSF number preceded by the words "Texas Department of Transportation Vehicle Storage Facility License Number" or "TxDOT VSF Lic. No.";

(F) a notice of the towed vehicle owner's right under Transportation Code, Chapter 685, to challenge the legality of the tow involved; and

(G) the name, mailing address, and toll-free telephone number of the Motor Carrier Division for purposes of directing questions or complaints.

(2) All published notifications shall state:

(A) the full name, street address, telephone number, and vehicle storage facility license number of the vehicle storage facility;

(B) a description of the vehicle; and

(C) the total amount of charges assessed against the vehicle.

(e) Nonconsent towed vehicle towed from private property. A VSF accepting a nonconsent towed vehicle towed from private property must report that tow to the local law enforcement agency for the area from which the vehicle was towed. This report must be made within two hours of receiving the vehicle. It must include the vehicle's license plate number and issuing state, vehicle identification number, and location from which it was towed. Facility records shall indicate specifically to whom the stated information was reported and in what manner, as well as the time and date of the report.

§18.88. Documentation and Records.

(a) Retention of written documentation. Vehicle storage facility licensees must maintain written documentation regarding their operations for a period of two years from the date such operations occurred. Written documentation shall be in the form of:

(1) motor vehicle registration checks;

(2) notification letters;

(3) certified return receipts;

(4) tow tickets or wrecker slips (if applicable);

(5) bills for service;

(6) auction receipts;

(7) inventory (if applicable);

(8) certificates of authority to demolish; and

(9) any authorized document used to release a vehicle (title, affidavit of right of possession and control, court order, etc.).

(b) Combination documents. Provided that the document contains the minimum information described in subsection (c) of this section, a licensee may consolidate the information required into a single document in order to meet record retention requirements of subsection (a) of this section. Combination documents may consist of:

(1) bills for service;

(2) inventory records;

(3) tow tickets; or

(4) wrecker slips (if applicable).

(c) Minimum information. Each licensee shall keep written records on each vehicle kept or stored at the vehicle storage facility. These records shall contain:

(1) the year, make, model, color, correct license plate number, state issuing the license, and correct vehicle identification number of the vehicle;

(2) the date, time and location from which the vehicle was towed, and name of person who authorized the tow;

(3) the name of the tow truck driver, the name of the company that towed the vehicle, and the license plate numbers of plates issued to the tow truck under Transportation Code, §502.180, and §504.508[~~, and former §502.281~~];

(4) the date the vehicle was released, the name of the individual to whom the vehicle was released, and the type of identification (Texas drivers license or other state or federally issued photo identification) and identification number provided by the individual to whom the vehicle was released;

(5) the date of any vehicle transfer, and the address of the location to which it was transferred along with the name of the towing company and tow truck driver who made the transfer;

(6) a copy of any certificate of title issued after the vehicle came into the possession of the vehicle storage facility, any certificate of authority to demolish, any police auction sales receipt, or any transfer document issued by the State of Texas for the vehicle if vehicle

ownership has been transferred due to any action of the vehicle storage facility or if the vehicle has been disposed of or demolished; and

(7) all amounts received at the time the vehicle was released, including the specific nature of each charge.

(d) Nonconsent tow tickets and wrecker slips. The VSF shall ensure that nonconsent tow tickets and wrecker slips (if applicable) contain the registered name of the tow truck company and the certificate of registration number on file with the department.

(e) Availability of documentation. All required documentation shall be made available by the licensee, the licensee's agent, or the licensee's employee for inspection and copying upon request by department personnel, or a certified law enforcement officer within the officer's jurisdiction, during the same hours the vehicle storage facility must ensure that vehicles are available for release to the vehicle owner.

(f) Care and custody of records. Required records shall be kept under the care and custody of the licensee for at least two years from the date the vehicle was received.

§18.89. Notice of Complaint Procedure.

Each vehicle storage facility shall notify consumers and service recipients of the name, mailing address, and telephone number of the department for purposes of directing complaints regarding vehicle storage to the department. The licensee may use a legible sticker or rubber stamp to convey the required information. The notice [~~notification~~] shall be included on:

(1) a sign prominently displayed to the public at the place of payment, with letters at least one inch in height, and a contrasting background; and

(2) the front page of any bill for service.

§18.90. Rights of Owner or Authorized Representative.

(a) A vehicle storage facility must allow a person claiming to be the owner of a vehicle stored or parked at the facility to have access to the vehicle's glove compartment, console, or other interior storage area if documents necessary to establish the person's identity or ownership of the vehicle are located in the glove compartment, console, or other interior storage area.

(b) When a person demonstrates ownership or right to possession of a motor vehicle stored at a VSF, the person and his/her authorized representative shall:

(1) be entitled to inspect a copy of the tow ticket or wrecker slip, as described in §18.88 of this subchapter, for the motor vehicle and shall not be required to pay any fees or charges before doing so (placing the ticket or slip behind a glass enclosure for the person to inspect satisfies this requirement);

(2) be given access to, and be allowed to remove, any personal belongings in the vehicle, unless otherwise indicated by a certified law enforcement officer (the VSF must require a receipt from the person to whom the personal belongings are released for any such property removed from the stored vehicle by the vehicle owner or authorized representative); and

(3) have access, during normal business hours, to the vehicle for the purposes of insurance and/or repair estimates.

(4) have access to the nonconsent towing fees schedule, as prescribed in §18.103 of this chapter (relating to Required Posting at Vehicle Storage Facility (VSF)), for the specific motor carrier involved in the transportation of the vehicle to the vehicle storage facility.

§18.91. Facility Requirements.

(a) Enclosure and security of stored vehicles.

(1) Fencing. If not enclosed by a five foot high fence on or before September 1, 1985, all vehicle storage facilities shall be completely enclosed by a fence at least six feet high with a gate which is locked at all times when the licensee or an agent or employee is not at the storage lot. No two vehicle storage facilities may operate within the same fenced area.

(2) Security of vehicles.

(A) No vehicle may be stored or kept at any licensed vehicle storage facility unless it is kept inside the fenced or enclosed area at all times. For purposes of this subsection, the term "enclosed" shall mean inside a building.

(B) A vehicle accepted for storage in a vehicle storage facility must be secured to prevent theft of the vehicle or its contents, including but not limited to locking doors, closing windows and hatchbacks, and raising or covering convertible tops.

(b) Surface. All vehicle storage facilities shall have an all-weather surface such as concrete, asphalt, black-top, stone, macadam, limestone, iron ore, gravel, shell, or caliche, that enables the safe and effective movement of stored vehicles upon all portions of the lot, both under their own power and under tow, at all times, regardless of prevailing weather conditions. The surface shall also be free of overgrown vegetation.

(c) Illumination. All vehicle storage facilities shall maintain illumination levels adequate for nighttime release of vehicles. The term "adequate" shall mean sufficient to allow inspection of a vehicle for damage at the time of release. At a minimum, there must be one lighting fixture containing at least a 250 watt element for each 1/4 acre of storage area.

(d) Signs.

(1) Facility information. All vehicle storage facilities shall have a clearly visible and readable sign at its main entrance. Such sign shall have letters at least 2 inches in height, with contrasting background, shall be visible at 10 feet, and shall contain the following information:

(A) the registered name of the storage lot, as it appears on the vehicle storage facility license;

(B) street address;

(C) the telephone number for the owner to contact in order to obtain release of the vehicle;

(D) the facility's hours, within one hour of which vehicles will be released to vehicle owners; and

(E) the storage lot's state license number preceded by the phrase "VSF License Number."

(2) Per diem charges. All vehicle storage facilities shall have a sign setting out the per diem charge for storage and all other fees which may be charged by the storage lot, including notification and impoundment fees. The sign shall include all forms of payments the VSF shall accept for any charge associated with delivery or storage of a vehicle. This sign shall be located so it is clearly visible to a vehicle owner at the place of payment and [~~prior to paying the fees,~~] shall have letters at least 1 inch in height[~~,~~] with a contrasting background.

(3) Nonconsent towing fees schedule. All vehicle storage facilities shall conspicuously place a sign, at the place of payment, that states in 1-inch letters that "Applicable schedules of nonconsent towing fees will be provided for viewing upon request by persons claiming vehicles." The nonconsent towing fees provided for viewing must match the nonconsent towing fees schedule on file with the department, as

provided in Subchapter H of this chapter (relating to Nonconsent Towing Fees Schedule).

(4) Instruments accepted for release of vehicle. All vehicle storage facilities shall have a sign describing the instruments which may be presented by the vehicle owner or his/her authorized representative to obtain possession of the vehicle. This sign shall list all instruments as described in §18.92(a)(3) of this subchapter, and shall also state: "Affidavit of Right of Possession and Control Furnished Upon Request." This sign shall be located so it is clearly visible to a vehicle owner at the place of payment, and have letters at least 1 inch in height with a contrasting background.

(5) Combination signs. A vehicle storage facility may combine the signs described in §18.89(1) of this subchapter and paragraphs (2), (3), and (4) of this subsection, provided that the combination sign meets the requirements of each of the separate signs.

(e) Unregistered tow trucks. No vehicle storage facility shall permit any tow truck which is not registered under Transportation Code, Chapter 643, to enter onto the grounds of the facility.

§18.92. Technical Requirements.

(a) Release of vehicles. The licensee shall comply with the following requirements when releasing vehicles.

(1) The licensee shall comply with all provisions of Texas Transportation Code, Chapter 685, relating to the rights of the owner of a stored vehicle, including providing the name, address, and telephone number of:

(A) the justice court that has [~~of the peace or magistrate from whose~~] jurisdiction in the precinct in which the vehicle storage facility is located; and [~~was removed.~~]

(B) the name, address and telephone number of the person or law enforcement agency that authorized the tow.

(2) The licensee shall provide the owner or the owner's representative with a tow ticket or wrecker slip as prescribed in §18.88 of this subchapter.

(3) Except as provided in subsection (a)(8) of this section, the [~~The~~] licensee shall allow the vehicle owner or his/her authorized representative to obtain possession of the vehicle at any time between the hours listed on the facility information sign posted as described in §18.91(d)(1) of this subchapter, upon payment of all fees due, presentation of valid identification (Texas drivers license or other state or federally issued photo identification), and upon presentation of:

(A) a notarized power-of-attorney;

(B) a court order;

(C) a certificate of title;

(D) a tax collector's receipt and a vehicle registration renewal card accompanied by a conforming identification;

(E) notarized proof of loss claim of theft from an insurance company to show a right to possession;

(F) positive name and address information corresponding to that contained in the files of the department's Vehicle Titles and Registration Division; or

(G) a department approved Affidavit of Right of Possession and Control, as defined in §18.82 of this subchapter, which is to be furnished by the licensee upon request (an Affidavit of Right of Possession and Control is not to be used as a repossession instrument).

(4) All vehicle storage facilities shall have vehicles available for release 24 hours a day within one hour's notice if it accepts vehicles 24 hours a day.

(5) If a vehicle storage facility does not accept vehicles 24 hours a day, such facility must have vehicles available for release within one hour between the hours of 8:00 a.m. and midnight Monday-Saturday and from 8:00 a.m. to 5:00 p.m. on Sundays except for nationally recognized holidays. It is not the intent of this section to require release of vehicles after midnight, and refusal to release after that time, even with notice after 11:00 p.m., is not a violation of this section.

(6) In addition to other forms of payment accepted by the vehicle storage facility, one of the following must be accepted for any charge associated with delivery or storage of a vehicle:

(A) credit card;

(B) debit card; or

(C) electronic check.

(7) the licensee may not refuse to release the vehicle to the vehicle's owner due to nonpayment by the law enforcement agency that directed the towing and storage of the vehicle for evidentiary or examination purposes. The licensee cannot charge the law enforcement agency for costs that accrued after the agency authorized the release of the vehicle.

(8) Pursuant to 37 TAC §4.16, relating to commercial vehicle regulations and enforcement procedures, a commercial motor vehicle stored at the direction of the Texas Department of Public Safety shall not be released until the amount of delinquent administrative penalty assessed against the motor carrier has been paid.

(b) Notification of insurance information. Upon request by the vehicle owner or the vehicle owner's authorized representative, the licensee shall provide the name, address, and telephone number of the insurance company that is providing required garage keeper's legal liability insurance coverage to the facility, in addition to the facility's insurance policy or certificate number for purposes of filing a claim for loss or damage of property. The insurance information shall be the same as that on file with the department.

(c) Publicly listed telephone number. All vehicle storage facilities shall have a publicly listed and operable telephone where the licensee can be contacted. If the telephone number is changed from the number set out in the vehicle storage license application, the licensee shall give the department written notice of the change prior to the date the new number is used. The notice shall include the storage lot's name, its location, its license number, the old telephone number, and the new telephone number.

(d) Inspection of stored vehicles. When the licensee, the licensee's agent, or the licensee's employee accepts a vehicle towed without the vehicle owner's consent, such person shall inspect the vehicle and note as an addition on the wrecker slip or wrecker ticket any differences from the information previously set out thereon, but shall not write over or deface any prior writing on the slip or ticket. If the license plate number or vehicle identification number on the wrecker ticket or wrecker slip are incorrect, the vehicle storage facility shall note on its records the correct number and notify every previously advised person within 48 hours of noting the correct information.

(e) Removal of parts; dismantling or demolishing of stored vehicles. Except as stated to the contrary in this section, no parts shall be removed from any vehicle, and no vehicle shall be dismantled or demolished within the storage area of a licensed vehicle storage facility. Vehicles may be dismantled or demolished only if the storage lot has

a certificate of title, certificate of authority to demolish, police auction sales receipt, or transfer document issued by the State of Texas for the vehicle being dismantled or demolished.

(f) Use of stored vehicles. No stored vehicle may be utilized for personal or business use without the written consent of the vehicle's owner.

(g) Reasonable storage efforts. A vehicle storage facility operator shall make reasonable efforts necessary for the storage of a vehicle, such as locking doors, rolling up windows, and closing doors, hatchbacks, sun roofs, trunks, hoods, or convertible tops. Such actions are included in the storage fee as set forth in §18.93 of this subchapter.

(h) Impoundment of stored vehicles. If doors, windows, convertible tops, hatchbacks, sun roofs, trunks, or hoods are broken or inoperative, materials such as plastic or canvas tarpaulins must be used to ensure the preservation of the stored vehicle. A vehicle storage facility operator is entitled to charge a fee for impoundment if, in addition to the requirements set out in this subsection, the vehicle storage facility operator, at a minimum:

(1) conducts a written inventory of any unsecured personal property contained in the vehicle;

(2) removes and stores all such property for which safekeeping is necessary, and specifies such removal and storage on the written inventory; and

(3) obtains motor vehicle registration information for the vehicle from the department.

(i) Repair or alteration of stored vehicles. A vehicle accepted for storage may not be repaired, altered, or have parts removed or replaced without the vehicle owner's or his authorized representative's consent.

(j) Vehicle transfers. When a motor vehicle has been delivered to a vehicle storage facility, the vehicle may not be moved from that facility within the first 31 days of storage without the vehicle owner's authorization. If it becomes necessary to move the vehicle during the first 31 days of storage because of vehicle storage facility capacity problems, neither the registered vehicle owner nor recorded lienholder(s) may be assessed an additional charge. The vehicle storage facility must send notice in accordance with §18.87 of this subchapter, except that the notice must be sent no less than 72 hours prior to moving the vehicle. If a vehicle is moved from a vehicle storage facility, the licensee shall:

(1) charge only those fees otherwise permitted by §18.93 of this subchapter after the vehicle is towed to another location without the vehicle owner's permission;

(2) retain records and inform the vehicle owner upon request of the location where the vehicle is at all times from the date on which the vehicle is transferred from the vehicle storage facility until such time as the vehicle is recovered by the vehicle owner, or a new certificate of title, a certificate of authority to demolish, a police auction sales receipt, or a transfer document is issued by the State of Texas; and

(3) maintain a record of the ultimate disposition of the vehicle, including the date and name of the person to whom the vehicle is released or a description of the document under which the vehicle was sold or demolished.

§18.93. Storage Fees and Charges.

The fees outlined in this section have precedence over any conflicting municipal ordinance or charter provision.

(1) Notification fee.

(A) A vehicle storage facility operator may not charge a vehicle owner more than $50 [~~$32~~] for notification under §18.87 of this subchapter. If a notification must be published as specified under §18.87 of this subchapter, and the actual cost of publication exceeds 50% of the notification fee, the VSF operator may recover the additional amount of the cost of publication. The publication fee is in addition to the notification fee.

(B) If a vehicle is removed by the vehicle owner within 24 hours after the date the operator receives the vehicle, notification is not required under §18.87 of this subchapter.

(C) If a vehicle is removed by the vehicle owner before notification is sent or within 24 hours from the time the operator receives the vehicle, the VSF operator may not charge a notification fee to the vehicle owner.

(2) Daily storage fee. A vehicle storage facility operator may not charge less than $5.00 or more than $20 [~~$15~~] for each day or part of a day for storage of a vehicle that is 25 feet or less in length. A vehicle storage facility operator shall charge a fee of $35 [~~$30~~] for each day or part of a day for storage of a vehicle that exceeds 25 feet in length.

(A) A daily storage fee may be charged for any part of the day, except that a daily storage fee may not be charged for more than one day if the vehicle remains at the vehicle storage facility less than 12 hours. In this paragraph a day is considered to begin and end at midnight.

(B) A vehicle storage facility operator that has accepted into storage a vehicle registered in this state shall not charge for more than five days of storage fees until a notice, as prescribed in §18.87 of this subchapter, is mailed or published.

(C) A vehicle storage facility operator that has accepted into storage a vehicle not registered in Texas shall not charge for more than five days before the date the request for owner information is sent to the appropriate governmental entity. Such requests shall be correctly addressed, with sufficient postage, and sent by certified mail, or electronic certified mail, return receipt requested, to the governmental entity with which the vehicle is registered requesting information relating to the identity of the last known registered owner and any lienholder of record.

(D) [~~(C)~~] A vehicle storage facility operator shall charge a daily storage fee after notice, as prescribed in §18.87 of this subchapter, is mailed or published for each day or portion of a day the vehicle is in storage until the vehicle is removed and all accrued charges are paid.

(3) Impoundment fee. A vehicle storage facility operator may charge a vehicle owner an impoundment fee if impoundment is performed in accordance with §18.92(h) of this subchapter. The impoundment fee may not exceed $20. If the vehicle storage facility operator charges a fee for impoundment, the written bill for services must specify the exact services performed for that fee and the dates those services were performed.

(4) Governmental or law enforcement fees. A vehicle storage facility operator may collect from a vehicle owner any fee that must be paid to a law enforcement agency, the agency's authorized agent, or a governmental entity.

(5) Additional fees. A vehicle storage facility operator may not charge any additional fees related to the storage of a vehicle other than fees authorized by this section or a nonconsent towing fee posted on a nonconsent towing fees schedule on file with the department and posted at the vehicle storage facility [~~that are similar to notification or~~

~~impoundment fees. A vehicle storage facility operator may not charge an administrative fee~~].

§18.96. Disposal of Certain Vehicles.

(a) Applicability. A VSF operator may not dispose of a vehicle unless the operator has complied with all provisions of the Act, including §§2303.151 - 2303.154 and 2303.157, concerning notification and disposal of abandoned vehicles.

(b) Notification of proposed disposal. A vehicle storage facility operator shall notify the registered owner and all recorded lienholders of the proposed disposal of the vehicle in accordance with §§2303.151 - 2303.154 of the Act concerning notification.

(c) Notification of abandonment. A vehicle storage facility operator shall notify law enforcement of the abandonment of the vehicle in accordance with §2303.154 of the Act.

(d) [~~(c)~~] Documentation and records. A vehicle storage facility operator shall keep complete and accurate records of any vehicle disposed of under §2303.157 of the Act. These records shall include:

(1) a copy of the VTR-265VSF form or its successor completed by the vehicle storage facility operator and provided to the vehicle buyer;

(2) copies of all notifications issued to the registered owner and all recorded lienholders, regardless of whether the notifications were mailed or published; and

(3) a copy of the VTR-71-6 form or its successor submitted to the department for authority to dispose of and demolish an abandoned nuisance vehicle.

(e) [~~(d)~~] Public sale. A vehicle storage facility operator may dispose of a vehicle through a public sale in compliance with §2303.157 of the Act. Disputes over the sale or dispersal of proceeds from the sale of the vehicle may be pursued through a court of appropriate jurisdiction.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505339
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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CHAPTER 25. TRAFFIC OPERATIONS
SUBCHAPTER A. GENERAL

43 TAC §25.1

The Texas Department of Transportation (department) proposes amendments to §25.1, Uniform Traffic Control Devices, concerning the Texas Manual on Uniform Traffic Control Devices (Texas MUTCD). The Texas MUTCD is amended periodically to maintain substantial compliance with the National Manual on Uniform Traffic Control Devices (National MUTCD), to allow use of a single manual for local, state, and Federal-aid highway projects. These amendments incorporate the latest federal requirements of the National MUTCD into the Texas MUTCD.

The National MUTCD defines the standards used by road managers nationwide to install and maintain traffic control devices on all streets and highways open to public travel. The National MUTCD is published by the Federal Highway Administration (FHWA) under Title 23, Code of Federal Regulations, Part 655, Subpart F.

The FHWA has recently completed a major revision and reformat of the National MUTCD. All states are required to adopt the provisions of this new federal manual.

Section 25.1(a) adopts by reference the 2006 Texas MUTCD. In addition, the amendments add bicycle trails to the types of transportation facilities in which the Texas MUTCD applies. This section also clarifies that the Texas MUTCD only applies to streets, highways, and bicycle trails that are open to public travel.

The amendment also provides that the Texas MUTCD will be available online through the department's website and will no longer be published. For those unable to access the department's website, copies are available on request. Subsections (d) and (e) are no longer necessary and are deleted from the proposed rule.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each of the first five years the amendments are in effect, there will be minimal fiscal implications for state or local governments as a result of enforcing or administering the amendments.

Traffic control devices that are installed after the adoption of the manual will be required to be in compliance with the standards of the new manual. There are minimal anticipated economic costs to persons required to comply with the amendments as proposed.

Carlos A. Lopez, P.E., Director, Traffic Operations Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT

Mr. Lopez also has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the amendments will be a more uniform use of traffic control devices and increased highway safety. There will be no adverse economic effects on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments may be submitted to Carlos A. Lopez, P.E., Director, Traffic Operations Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments will be 5:00 p.m. on January 2, 2006.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which authorizes the Texas Transportation Commission to promulgate rules for the conduct of the work of the department.

CROSS REFEREMCE TO STATUTE

Transportation Code §544.001

§25.1. Uniform Traffic Control Devices.

(a) The 2006 [~~2003~~] Texas Manual on Uniform Traffic Control Devices, which is filed with this section and hereby incorporated by reference, was prepared as required by law to govern standards and specifications for all such traffic control devices to be erected and maintained upon all streets, highways, and bicycle trails that are open to public travel within this state, including those under local jurisdiction. Copies of the manual are available online through [~~may be obtained at~~] the Texas Department of Transportation web site, www.dot.state.tx.us [~~, 125 East 11th Street, Austin, Texas 78701~~], and are on file for public inspection with the Office of the Secretary of State, Texas Register Division, James Earl Rudder State Office Building, Room 245, Austin, Texas 78711.

(b) This manual will be periodically updated. In the intervals between updates, standards contained in "Official Rulings on Requests for Interpretations, Changes, and Experimentation" to the United States Department of Transportation's Manual on Uniform Traffic Control Devices for Streets and Highways will be inserted in this manual and may be used as interim standards.

(c) This manual is not intended to preclude the use of sound engineering judgment and experience in the application and installation of devices and particularly in those cases not specifically covered which must not conflict with the manual or other applicable state laws.

[~~(d) This manual will be sold for a price based upon the then current cost to the department, except that certain public entities may be entitled to free copies.~~]

[~~(e) The manual will be available on the department's internet website at www.dot.state.tx.us.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505340
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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SUBCHAPTER B. PROCEDURES FOR ESTABLISHING SPEED ZONES

43 TAC §§25.21, 25.23, 25.25

The Texas Department of Transportation (department) proposes amendments to §§25.21, 25.23 and 25.25 concerning procedures for establishing speed zones.

EXPLANATION OF PROPOSED AMENDMENTS

House Bill 2257, 79th Legislature, Regular Session, 2005, expands the number of counties that are eligible for a maximum 75 mile per hour daytime speed limit as established by the Texas Transportation Commission (commission). House Bill 2257 also authorizes the commission to establish a maximum speed limit of 80 miles per hour on Interstate Highway 10 and Interstate Highway 20 in certain counties.

Section 25.21, Introduction, implements the legislative changes by adding the counties that now qualify for the 75 mile per hour speed limit. The amendment also states the counties eligible for the 80 mile per hour speed limit as authorized in House Bill 2257. Amendments to this section also note that the maximum speed allowed on a portion of the Trans-Texas Corridor is 85 miles per hour as authorized under Transportation Code, §545.3531.

Various changes to §25.23, Speed Zone Studies, allow a four hour observation period for a speed study if performed with a traffic counter that classifies vehicles by type. These changes reflect current agency practice and are non-substantive in nature.

Section 25.23(c)(5), clarifies that when a study indicates that the 85th percentile speed is at or below 50 miles per hour, the resulting school zone speed limit should not be set more than 15 miles per hour below the 85th percentile speed. The current language only states that this requirement applies to 85th percentile speeds of below 50 miles per hour. This is not a significant change and is included only as clarification.

Section 25.25, Application of Advisory Speeds, is amended to allow for the use of manual or electronic ball-bank indicators for use in determining the advisory speed limit for curves and turns. The Procedures for Establishing Speed Zones Manual (procedures manual) includes detailed information on the use of the ball-bank indicator, therefore, all references about how to use the ball-bank indicator have been deleted from the proposed rule. Figures 2, 4, and 5 in §25.25 are deleted. By deleting §25.25(b)(3) - (8), the department is able to update the procedures manual to accommodate the use of new technology.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each of the first five years the amendments as proposed are in effect, there will be no significant fiscal implications for state or local governments as a result of enforcing or administering the amendments. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Carlos A. Lopez, P.E., Director, Traffic Operations Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT

Mr. Lopez has also determined that for each of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be more efficient operation of the state highway system, more uniform creation of speed limits on the state highway system, and implementation of the requirements of House Bill 2257. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments may be submitted to Carlos A. Lopez, P.E., Director, Traffic Operations Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 2, 2006.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §545.353, and §545.3531

§25.21. Introduction.

(a) (No change.)

(b) Background.

(1) (No change.)

(2) Authority to set speed zones.

(A) (No change.)

(B) Transportation Code, §545.353, subsections (h) and (i), address the commission's authority to establish a daytime speed limit of 75 or 80 miles [~~mile~~] per hour on a portion of the state highway system.

(i) The commission may establish [~~such~~] a 75 mile per hour speed limit in counties with a population density of less than 15 [~~10~~] persons per square mile. Counties that are currently eligible for this higher maximum daytime speed limit are Andrews, Archer, Armstrong, Bailey, Baylor, Blanco, Borden, Brewster, Briscoe, Brooks, Callahan, Carson, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Deaf Smith, Dickens, Dimmit, Donley, Duval, Edwards, Fisher, Floyd, Foard, Frio, Gaines, Garza, Glasscock, Goliad, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hudspeth, Irion, Jack, Jeff Davis, Jim Hogg, Kenedy, Kent, Kimble, King, Kinney, Knox, Lamb, La Salle, Leon, Lipscomb, Live Oak, Loving, Lynn, Martin, Mason, McCullough, McMullen, Menard, Mills, Mitchell, Motley, Ochiltree, Oldham, Parmer, Pecos, Presidio, Reagan, Real, Red River, Reeves, Refugio, Roberts, Runnels, San Saba, Schleicher, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terrell, Terry, Throckmorton, Upton, Val Verde, Ward, Wheeler, Winkler, Yoakum, Zapata, and Zavala.

(ii) The department will reevaluate which counties are eligible for [~~such~~] a 75 mile per hour speed limit upon the release of each decennial federal census of the population.

(iii) The commission may establish a speed limit of 80 miles per hour for daytime on parts of Interstate Highway 10 and of Interstate Highway 20 in Crockett, Culberson, Hudspeth, Jeff Davis, Kerr, Kimble, Pecos, Reeves, Sutton, or Ward counties.

(iv) [~~(iii)~~] In order to establish a 75 or 80 mile per hour daytime speed limit in an eligible county, the commission must determine that a 75 or 80 mile per hour speed limit is safe and reasonable.

(v) [~~(iv)~~] A 75 or 80 mile per hour speed limit established under this section does not apply to trucks (other than light trucks and light trucks pulling a trailer), truck tractors, trailers, and semitrailers.

(C) (No change.)

(D) Transportation Code, §545.355 and §545.356, give counties and cities the same authority within their respective jurisdictions. The law also provides that any speed zone on highway routes in cities established by commission minute order will supersede any conflicting zone set by city ordinance or resolution.

(E) - (K) (No change.)

(L) Transportation Code, §545.3531, authorizes the commission to establish a speed limit of not more than 85 miles per hour on the Trans-Texas Corridor.

(3) (No change.)

(c) (No change.)

§25.23. Speed Zone Studies.

(a) (No change.)

(b) Determining the 85th percentile speed.

(1) - (2) (No change.)

(3) Operation of speed check stations.

(A) Normal speed checks should:

(i) - (iv) (No change.)

(v) be discontinued after two hours using a radar or four hours if performed by a traffic counter that classifies vehicles by type, even if 125 cars have not been timed.

(B) - (C) (No change.)

(4) Location of speed check stations.

(A) - (B) (No change.)

(C) In rural areas, speed check stations:

(i) - (ii) (No change.)

(iii) may be determined by trial runs through the area if the characteristics of the roadway are consistent throughout the entire section and a speed check in that section indicates that 125 vehicles cannot be checked in the two hours using a radar or four hours if performed by a traffic counter that classifies vehicles by type.

(5) (No change.)

(c) Schools.

(1) - (4) (No change.)

(5) When the results of a speed study indicate an 85th percentile speed at or below 50 miles per hour, the reduced school speed limit should not be more than 15 miles per hour below the 85th percentile speed or normal posted speed limits. If the 85th percentile speed is 55 miles per hour, the reduced school speed limit should be 20 miles per hour below the 85th percentile speed. Any roadway with an 85th percentile speed greater than 55 miles per hour requires a buffer zone to transition down to a 35 mile per hour speed limit.

(6) (No change.)

(d) Speed zone design.

(1) - (4) (No change.)

(5) Variation from 85th percentile.

(A) The posted speed selected is the nearest value ending in 5 or 0. The final speed limit may be lowered or raised by as much as 5 miles per hour from the 85th percentile speed or trial-run speed (performed if 125 cars cannot be checked during the two or four hour speed check) based on the professional judgment of the supervising engineer. Only under special conditions would the zone speed vary further from the 85th percentile. Explanations of such conditions follow.

(i) - (ii) (No change.)

(iii) Light traffic volumes. At locations where traffic volumes are light and 125 cars cannot be checked in the two or four hours that the speed check station is operated, the 85th percentile speed may not be reliable. Trial runs need to be made and documented in the study.

(iv) (No change.)

(v) Additional roadway factors. The posted speed limit may be reduced by as much as 10 miles per hour (12 miles per

hour for locations with crash rates higher than the statewide average) below the 85th percentile speed or trial-run speed (performed if 125 cars cannot be checked during the two or four hour speed check) based on sound and generally accepted engineering judgment that includes consideration of the following factors:

(I) - (VII) (No change.)

(B) - (C) (No change.)

(D) Speed limits should not be posted more than 10 miles per hour (12 miles per hour for locations with crash rates higher than the statewide average) below the 85th percentile or trial-run speed (performed if 125 cars cannot be checked during the two or four hour speed check) since unreasonably low speed limits have not been shown to be an effective way to control speeding. Allowing too great a variation would risk losing motorist respect for speed limits and traffic control devices.

(6) - (8) (No change.)

(e) - (f) (No change.)

§25.25. Application of Advisory Speeds.

(a) Overview.

(1) (No change.)

(2) Advisory speed sign posting.

(A) - (B) (No change.)

(C) The following Figure [1] shows typical warning and advisory speed signing applications.
Figure [1]: 43 TAC §25.25(a)(2)(C)

(b) Curves and turns.

(1) Introduction

(A) - (B) (No change.)

(C) The speed to be posted will be based on results obtained from test runs in a vehicle equipped with a [the] ball-bank indicator, not the calculated value. The ball-bank indicator can be electric or manual. [Examples of ball-bank indicators are shown in the following Figure 2. (See discussion of "Calculated Speed" in paragraph (2) of this subsection).]
[Figure 2: 43 TAC §25.25(b)(1)(C)]

(2) Calculated speed.

(A) For curves and turns, the calculated speed is to be used as a guide for making the initial test run and as a check on the speed obtained by the use of the ball-bank indicator. The calculated speed is not, however, to be used as the sole basis for selecting the posted speed. See "Selecting Speed for Posting" in paragraph (3) [(9)] of this subsection for additional discussion.

(B) Calculate the design speed of the curve under consideration using the following formula.
Figure [3]: 43 TAC §25.25(b)(2)(B)

[(3) Selection of car and mounting of ball-bank indicator.]

[(A) Select an average passenger car for making the test runs and mount the ball-bank indicator on the center line of the dash.]

[(i) Suitable metal strap mountings can be made on which to mount the indicator, as shown in the following Figure 4.]
[Figure 4: 43 TAC §25.25(b)(3)(A)(i)]

[(ii) The metal strap holding the right-hand side of the indicator on dash mountings should be slotted and a thumb nut provided so the steel ball can be adjusted to the zero degree position by raising or lowering the right side of the indicator.]

[(B) If there is any doubt about the selection of an average car, a ball-bank indicator should be mounted on three different makes or year models for a check.]

[(4) Before conducting test runs. To ensure proper operation of the ball-bank indicator, it is critical that the following steps be taken before conducting test runs.]

[(A) Inflate all tires to the uniform pressure used during speedometer calibration.]

[(B) Calibrate the test vehicle's speedometer in accordance with paragraph (5) of this subsection.]

[(C) Zero the ball-bank indicator (see procedure in paragraph (6) of this subsection).]

[(5) Calibrating speedometer.]

[(A) It is essential that speedometers be calibrated accurately so that advisory speeds will be uniform throughout the state.]

[(B) Calibrate the speedometer for recording of speed. The accuracy of the odometer for recording distance should be checked against a measured distance. Calibration for speed can be done easily with a radar speed meter or by timing the car over a measured distance. The speedometer should be checked for each 5 mile per hour interval over 20 miles per hour, and several test runs should be made for each speed so that an average value may be obtained.]

[(6) Zeroing the ball-bank indicator.]

[(A) The ball-bank indicator must be adjusted to the zero reading before test runs are conducted.]

[(B) This must be done with the car straddling the center line of the pavement on a tangent section to give the effect of a flat level surface, and the driver and recorder in the same position in which they will ride during the test runs. It is essential that the driver and recorder be in the same position when the ball-bank indicator is set to the zero reading as they will be when the test runs are made, because a shift in the load is reflected in a change of the ball-bank indicator reading.]

[(7) Conducting ball-bank indicator test runs.]

[(A) The curve should be driven at the calculated speed described in paragraph (2) of this subsection on the initial run.]

[(B) If the calculated speed is not available, the curve should be driven at an estimated speed approximately 5 miles per hour slower than that which the driver feels he or she can maintain throughout the entire length of the curve.]

[(C) Each succeeding run should be made at a speed 5 miles per hour greater than the preceding run until the ball-bank indicator reading reaches:]

[(i) 10 degrees for speeds of 35 miles per hour or more;]

[(ii) 12 degrees for speeds of 25 and 30 miles per hour; or]

[(iii) 14 degrees for speeds of 20 miles per hour or less.]

[(D) On each test run, the driver should reach the test run speed at a distance of at least 0.25 mile from the beginning of the curve and maintain this speed throughout the entire length of the curve. The path of the car throughout the curve should be maintained as nearly as possible in the center of the right hand lane.]

[(E) Test runs should be made in each direction on each curve.]

[(F) On each of the speeds of the test runs, the observer must carefully note the position of the ball throughout the length of the curve and record the maximum deflection in degrees. The readings should be interpolated as closely as possible to the nearest degree.]

[(8) Alternate ball-bank indicator test run method. An alternate procedure, intended to minimize the number of test runs required to determine the speed for which the curve is to be posted, is as follows.]

[(A) Drive the car at a speed of 5 miles per hour around the curve, staying as nearly as possible in the center of the right hand lane, and record the maximum deflection of the ball-bank indicator in degrees.]

[(i) Record the reading of the ball-bank indicator as plus if the deflection of the ball is to the right on a right hand curve and to the left on a left hand curve.]

[(ii) Record the reading of the ball-bank indicator as minus if the deflection of the ball is to the left on a right hand curve and to the right on a left hand curve.]

[(B) Drive around the curve at a constant speed that can be maintained without acceleration or deceleration and without driving outside the right-hand traffic lane.]

[(i) Record the maximum deflection of the ball-bank indicator.]

[(ii) Record the speed at which the curve was driven.]

[(C) Compute the maximum safe speed for the curve by solving the following formula for V2:]
[Figure 5: 43 TAC §25.25(b)(8)(C)]

[(D) Drive around the curve, staying in the right-hand lane, at the calculated speed V2 without acceleration or deceleration as a check on measurements and computations. The ball-bank indication recorded at speed V2 should then be:]

[(i) 10 degrees for speeds of 35 miles per hour or more;]

[(ii) 12 degrees for speeds of 25 and 30 miles per hour; or]

[(iii) 14 degrees for speeds of 20 miles per hour or less.]

(3) [(9)] Selecting speed for posting.

(A) Remember, the speed to be posted shall be based on the results obtained from test runs with the ball-bank indicator [(described in paragraphs (7) and (8) of this subsection)], not the calculated value.

(B) The posted speed shall be a multiple of 5 miles per hour.

(C) In selecting the speed to be posted, care should be taken that the calibrated speed for any given speedometer reading is used rather than the speedometer reading itself.

(D) As a final check, the posted speed is aimed at the highest value that will permit the average car to travel around the curve in its own lane without causing an uncomfortable side throw to its passengers.

(E) The speed to be posted on the curve should not be reduced arbitrarily below that determined by ball-bank indicator test runs [the procedures provided in this subsection].

(F) When there is a reverse curve or a series of three or more curves, the advisory speed sign shall show the value for the curve having the slowest safe speed in the series.

(c) - (d) (No change.)

(e) Descending grades of six percent or greater.

(1) - (2) (No change.)

(3) Calculation. Using the minimum sight distance as the safe stopping distance, the critical speed should be calculated from the following formula.
Figure [6]: 43 TAC §25.25(e)(3)

(4) (No change.)

(f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505341
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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SUBCHAPTER C. CONGESTION MITIGATION FACILITIES

43 TAC §25.41

The Texas Department of Transportation (department) proposes amendments to §25.41, Definitions, concerning congestion mitigation facilities.

EXPLANATION OF PROPOSED AMENDMENTS

House Bill 1986, 79th Legislature, Regular Session, 2005, adds a coordinated county transportation authority as created under Transportation Code, Chapter 460, to the list of entities that the department may enter into an agreement with for the design, construction, operation, or maintenance of a high occupancy vehicle lane.

The proposed amendment to §25.41(8), HOV Authority, adds a coordinated county transportation authority to the list of transit authorities that qualify as an HOV Authority. This will allow the department to enter into an agreement relating to HOV lanes with such an authority as required under the terms of the legislation.

FISCAL NOTE

James Bass, Chief Financial Officer, has determined that for each of the first five years the amendments as proposed are in effect, there will be no significant fiscal implications for state or local governments as a result of enforcing or administering the proposed amendment. There are no anticipated economic costs for persons required to comply with the section as proposed.

Carlos A. Lopez, P.E., Director, Traffic Operations Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the proposed amendments.

PUBLIC BENEFIT

Mr. Lopez has also determined that for each of the first five years the section is in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be more efficient operation of the state highway system and implementation of House Bill 1986. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments to §25.41 may be submitted to Carlos A. Lopez, P.E., Director, Traffic Operations Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 2, 2006.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §224.153(b)

§25.41. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) -(7) (No change.)

(8) HOV Authority--A transit authority created under Transportation Code, Chapter 451, 452, or 453; a regional mobility authority created under Transportation Code, Chapter 361 or 370; a municipality; [~~or~~] a transportation corporation; or a coordinated county transportation authority created under Transportation Code, Chapter 460.

(9) - (14) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505342
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 1, 2006
For further information, please call: (512) 463-8630

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WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 10. COMMUNITY DEVELOPMENT

PART 7. TEXAS RESIDENTIAL CONSTRUCTION COMMISSION

CHAPTER 303. REGISTRATION

SUBCHAPTER A. REGISTRATION OF BUILDERS

10 TAC §303.19

The Texas Residential Construction Commission withdraws the proposed amendment to §303.19 which appeared in the June 24, 2005, issue of the *Texas Register* (30 TexReg 3704).

Filed with the Office of the Secretary of State on November 17, 2005.

TRD-200505320
Susan K. Durso
General Counsel
Texas Residential Construction Commission
Effective date: November 17, 2005
For further information, please call: (512) 463-2886

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TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 13. FINANCIAL PLANNING

SUBCHAPTER H. REPORTING OF TUITION AND FEES

19 TAC §§13.140 - 13.143

The Texas Higher Education Coordinating Board withdraws proposed new §§13.140 - 13.143 which appeared in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5473).

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505384
Jan Greenberg
General Counsel
Texas Higher Education Coordinating Board
Effective date: November 21, 2005
For further information, please call: (512) 427-6114

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TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 108. PROFESSIONAL CONDUCT

SUBCHAPTER A. PROFESSIONAL RESPONSIBILITY

22 TAC §108.7

The State Board of Dental Examiners withdraws the proposed amendment to §108.7 which appeared in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5526).

Filed with the Office of the Secretary of State on November 17, 2005.

TRD-200505323
Jim Zukowski, Ed.D.
Executive Director
State Board of Dental Examiners
Effective date: November 17, 2005
For further information, please call: (512) 475-0972

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22 TAC §108.8

The State Board of Dental Examiners withdraws the proposed amendment to §108.8 which appeared in the September 16, 2005, issue of the *Texas Register* (30 TexReg 5895).

Filed with the Office of the Secretary of State on November 17, 2005.

TRD-200505324
Jim Zukowski, Ed.D.
Executive Director
State Board of Dental Examiners
Effective date: November 17, 2005
For further information, please call: (512) 475-0972

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PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 273. GENERAL RULES

22 TAC §273.4

The Texas Optometry Board withdraws the emergency amendment to §273.4 which appeared in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5459).

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505288

Chris Kloeris
Executive Director
Texas Optometry Board
Effective date: December 6, 2005
For further information, please call: (512) 305-8502

ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the the rule (Government Code, §2001.036). If a rule is adopted without change to the text as published in the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 5. TEXAS BUILDING AND PROCUREMENT COMMISSION

CHAPTER 125. SUPPORT SERVICES DIVISION--TRAVEL AND VEHICLE

SUBCHAPTER A. TRAVEL MANAGEMENT SERVICES

1 TAC §§125.1, 125.3, 125.5, 125.7, 125.9, 125.11, 125.15, 125.17, 125.19, 125.21, 125.23, 125.25, 125.29

The Texas Building and Procurement Commission (TBPC) adopts the repeal of 1 TAC, Chapter 125, Subchapter A, §§125.1, 125.3, 125.5, 125.7, 125.9, 125.11, 125.15, 125.17, 125.19, 125.21, 125.23, 125.25 and 125.29, concerning the travel management program. The repeal is adopted without changes to the proposal as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6349).

This repeal is proposed because a new Title 1, Chapter 125, Subchapter A was simultaneously proposed in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6350) and is being adopted elsewhere in this issue. The new Subchapter A revises the TBPC's travel management program rules to conform to 2003 and 2005 legislative changes, reorganizes the sections for enhanced clarity and ease of use, and emphasizes the use of lowest cost travel services.

These rules are being repealed to allow new rules to go into effect.

No comments were received regarding the repeals.

The repeals are adopted under Texas Government Code §§2171.002, 2171.054 and 2171.056 authorizing the TBPC to adopt rules relating to the travel management program.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505332
Ingrid K. Hansen
General Counsel
Texas Building and Procurement Commission
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-7829

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1 TAC §§125.1 - 125.8

The Texas Building and Procurement Commission (TBPC) adopts with changes new 1 TAC Chapter 125, Subchapter A, §§125.1 - 125.8, relating to travel services. All sections are adopted with changes to the proposed text as published in the October 7, 2005, of the *Texas Register* (30 TexReg 6350).

The new subchapter revises the TBPC's travel management program rules to conform to 2003 and 2005 legislative changes, reorganizes the sections for enhanced clarity and ease of use, and emphasizes the use of lowest cost travel services.

Summary of and Response to Comments. The TBPC received comments from the General Land Office, Comptroller of Public Accounts, Office of Court Administration and University of Texas. Changes to the proposed rules were made based on the comments. The TBPC appreciates the thoughtful and helpful comments received from these entities.

The Appropriations Act, Art. IX, Part 5, SB 1, 79th Leg., relating to Travel Regulations, requires compliance with Government Code, Chapter 660 and the Comptroller's Rules. Nothing in these rules shall be construed to alter, amend or modify the legal requirements in any statute or other regulations related to state travel.

Section 125.1 and §125.2. Two commenters requested clarifications regarding mandatory use of state travel contracts. Pursuant to Government Code §2171.055(b), institutions of higher education are required to use travel service contracts, except when the funds are from sources other than general revenue or educational and general funds as defined in Education Code §51.009. When institutions of higher education spend general revenue funds or educational and general funds as defined in Education Code §51.009, they must use the contract travel services, which include the contract travel credit card. The purpose of requiring use of the contract travel credit card is uniform tracking and reporting of state travel expenditures.

One commenter noted the definition in §125.1(b)(1) requires all state agency officials and employees to use contracted services, but §125.2 (relating to state agency) includes the judiciary. This commenter correctly pointed out that only executive branch agencies are required to use contract travel services. The judiciary is not required to use, but may use, state travel contracts. Government Code §2171.055(a) requires state agencies in the executive branch to participate in travel services contracts. Clearly this does not include the judiciary; however, officers and employees in the judicial branch may use the contract travel services by agreement with the TBPC pursuant to Government Code §2171.051.

The TBPC will revise proposed §125.1 to specify executive branch agencies. This commenter also suggested adding the judiciary to the list of entities entitled to use contract travel services. The TBPC will add judiciary and institutions of higher education to the list of entities, in §125.1(b)(2), who may use the contract travel services and will remove them from the definition of state agency in §125.2. The changes resulting from this comment make the rules consistent with Government Code §2171.055 which requires only state agencies in the executive branch to use contract travel services. The Appropriations Act, Art. IX, Part 5, §5.02, SB 1, 79th Leg., relating to Travel Regulations, requires that appropriated funds used for transportation, meals, lodging or incidental expenses be expended in compliance with Government Code, chapter 660 and the Comptroller's Rules. Further, §5.01 and §5.02 incorporate the definitions of state agency in Government Code §660.002. These rules do not alter, amend or affect Government Code, Chapter 660 or Art. IX of the Appropriations Act.

Section 125.3. Two commenters noted that proposed §125.3(a) created confusion regarding when exceptions must be reported. The TBPC agrees the language, as proposed, requires clarification. Therefore the adopted rule is modified to remove the word "lower" in the last sentence of §125.3. One commenter asked whether rental of certain vehicles or flight to a destination, not available on state contract, must be reported as exceptions. These items must be reported as exceptions and the language of §125.3(c) relating to the unavailability of contract travel services, is being modified to clarify that complete unavailability of the service, in addition to unavailability relating to time or location, is a reportable exception.

One commenter noted that §125.3(d) relating to special needs, could create the impression that medical costs would be payable through a travel voucher. The special needs exception should be used sparingly and should be based upon a documented bona fide medical need requiring non-contracted services. The special needs exception does not authorize reimbursement for medical services provided to a traveler invoking the exception. In response to this comment, the TBPC will add a sentence in subsection (a) stating that the exceptions do not affect the Comptroller's reimbursement requirements or audit authority.

Section 125.4. One commenter asked whether a state agency or governmental entity that is not required to use contract travel services must get approval from the TBPC for entering into their own travel services contracts. Agencies and entities that are not required to use contract travel services, may enter into their own contracts for such services without prior approval from the TBPC. The TBPC is amending §125.4 by adding a modifying phrase to limit the section to those entities required to use contract travel services.

Section 125.6. One commenter noted that subsection (b) may be construed to imply that the Comptroller will conduct pre-payment audits of travel vouchers. Government Code §403.71(g) authorizes the comptroller to enter into agreements with state agencies for post-payment audits and this rule should not be construed to supercede the statute. The TBPC agrees that this section does not affect the authority of nor seek to impress duties upon the Comptroller. The TBPC is amending §125.3(a) to affirmatively state that nothing in these rules affects the comptroller's reimbursement or audit authority.

This commenter also noted that §125.6(b) should be clarified to state that higher reimbursements may occur where the exceptions granted under §125.4 apply. The TBPC agrees with the commenter and the adopted rule adds exceptions granted under §125.4.

Proposed §125.6(e) relating to state agency reporting requirements did not specify the reporting parameters and methods. One commenter asked for more specificity. The TBPC is amending §125.6(e) in response to this comment. Section 125.6 is being proposed for adoption with an expansion of subsection (e). The reporting requirement applies only to expenditures not purchased by state credit card. The TBPC encourages the use of state credit cards for all travel related purchases, even when the purchaser is not required to use contract travel services due to statutory exemption or due to an exception under §125.3. Section 125.6(e) requires reporting of expenditures for all travel related services. Additionally, the methods of reporting are listed and include an option to report directly to the TBPC's website at *www.tbpc.state.tx.us* when the web based travel reporting mechanism becomes functional.

One commenter asked whether travel services not purchased by state credit card must be reported under §125.6(e). The reporting requirement applies only to travel services not purchased on state travel credit cards. Finally, the TBPC is investigating web-based reporting to make the reporting less burdensome. State agencies will be notified when a new reporting method is available.

Section 125.8. One commenter asked whether state credit cards must be used to purchase non contract travel services. All contract airline travel must be purchased by state travel credit card. This is a requirement of the contract with the airline providers. Agencies required to participate in the contract travel services should use the state travel credit card for all travel purchases, when feasible. The purchase non-contract travel services by state credit card eliminates the need to report the expenditure under §125.6(e), thereby reducing state agency paperwork. Further, the use of the state travel credit cards provides benefits to the general revenue, where the rebates from the use of the cards are deposited. Governmental entities and state agencies that are not required to use contract travel services are not required to use state travel credit cards unless they choose to participate in airline contract travel services. Such persons and entities are also encouraged to use the state travel credit cards when feasible for ease of tracking and reporting travel expenditures. The TBPC is amending §125.8(a) by adding language to clarify the requirement to use the state travel credit card.

The TBPC has made other grammatical and word changes that do not affect the substance of the proposed rules. One such change is the use of the phrase "contract travel services," in the adopted rules; the proposed rules used the phrase "contracted travel services."

These rules are adopted pursuant to Government Code §2171.002, relating to the structure of travel agency contracts, procedures for soliciting travel agency contracts, and use of contract travel services for state agencies; §2171.055 relating to participation in contract travel services by governmental entities; and §2171.056 relating to exceptions from the use of contract travel services. These rules incorporate the suggestion in the General Appropriations Act, Art. IX, section 5.09, S.B.1, 79th Leg., relating to efforts to reduce travel expenses.

§125.1. Purpose and Applicability.

(a) Purpose. This subchapter governs the use of contract travel services and state travel credit cards by state officials and employees and other eligible persons. Contract travel services may include state

credit cards, travel agencies, airlines, vehicles, internet based reservation and ticketing, lodging and other modes and necessities of state business related travel. The purpose of this subchapter is to encourage travelers to obtain the lowest overall cost of travel services. These rules do not alter, amend or affect the requirements in Government Code, Chapter 660 relating to travel or the comptroller's statutes and rules.

(b) Applicability. This subsection defines the persons and entities eligible to use contract travel services.

(1) State Agencies. State agency officials and employees, in the executive branch, shall use the contract travel services as required by this subchapter whenever those services provide the most efficient travel resulting in the total lowest cost. State agencies may and are encouraged to purchase travel services at rates lower than the contract travel services rates.

(2) Other Governmental Entities. Officers and employees of the following entities may, but are not required to, participate in the travel services pursuant to this subchapter. These entities may use contract travel services upon TBPC approval of their application for the use of contract travel services.

(A) an institution of higher education as defined in Education Code §61.003 when the entity uses travel agency services or when the services are purchased from funds other than general revenue or education or general funds as defined by Education Code §51.009.

(B) Employees Retirement System when the travel is paid from other than general revenue funds;

(C) counties;

(D) municipalities;

(E) public junior colleges;

(F) school districts;

(G) emergency communication districts; and

(H) the Supreme Court, the Court of Criminal Appeals, the courts of appeals, and other entities in the judicial branch.

(c) Official Government Business. Contract travel services shall be used only for official governmental business, unless the travel services contractor offers the same services for personal use. No contractor is required to allow the use of contract travel services for other than official governmental business.

§125.2. Definitions.

The following words and terms, used in this subchapter, are defined as follows unless the context clearly indicates otherwise.

(1) Comptroller--The Comptroller of Public Accounts of the State of Texas.

(2) Contractor--An individual or entity under contract with TBPC for the provision of travel services.

(3) Contract travel services--The travel services provided pursuant to TBPC contracts that guarantee prices and levels of services for all eligible entities and individuals.

(4) Force Majeure event--Any acts of god, war, riot, strike, or other event beyond the control of a contractor and that could not reasonably have been anticipated or avoided and which, by the exercise of all reasonable due diligence, such contractor is unable to overcome.

(5) Official government business--Business required in the scope and course of the traveler's employment that is properly authorized by the employing governmental entity.

(6) State agency--State agency means any department, commission, board, office, council or other agency in the executive branch of state government created by the constitution or by statute that is required to use contract travel services pursuant to Government Code §2171.055.

(7) State employee--Any person employed by a state agency, or an elected or appointed official.

(8) State travel credit card--A credit card issued to an individual or a governmental entity by a contract travel credit card contractor.

(9) State travel directory--A TBPC publication that lists current available contract travel services.

(10) TBPC--Texas Building and Procurement Commission.

(11) Traveler--Any person eligible to use contract travel services, including those eligible pursuant to the comptroller's travel allowance guide.

§125.3. Exceptions to the Use of Contract Travel Services.

(a) This section provides exceptions to use of contract travel services. These exceptions apply to the use of any contract travel services. When travel services are obtained at a lower total cost than the cost of contract travel services, no reporting of exceptions is required. Exceptions must be documented only when the total cost is greater than contract travel services rates. Nothing in this section affects or alters the authority of the comptroller regarding travel reimbursement or audit agreements.

(b) Lower Cost to the State. State agencies may use any travel services obtained at a price lower than the contract travel services price. State agencies are encouraged to obtain lower priced travel services through the use of fourteen day or other advanced reservations programs, promotional price reductions, or any method that provides a lower overall cost of travel.

(c) Unavailability of Contract Travel Services. The contract travel services are not available during the time or at the location necessary for the business purpose; or the contract travel service does not provide for the service required; or because the contractor is unable to provide the contract services due to a force majeure event.

(d) Special Needs. The traveler's health, safety, physical condition or disability requires accommodations, including medical emergency or other necessary services, not available from contract travel service contractors.

(e) Custodians of Persons. The traveler has custody of a person pursuant to statute or court order and the traveler is required to provide a degree of security and safety that is not available from contract travel service contractors.

(f) In Travel Status. The traveler is in the course of travel and changes in scheduling render the use of contract travel services impractical or the appropriate travel services are not available. The traveler shall make reasonable efforts to secure rates equal to or lower than the contract travel service rates.

(g) Group Program. The traveler is using a group program wherein reservations were made through a required source to obtain a particular rate or service.

(h) Emergency Response. The traveler is responding to a public health or safety emergency situation.

(i) Legally Required Attendance. The traveler is required by a court, administrative tribunal or other entity to appear at a particular

time and place without sufficient notice to obtain contract travel services.

§125.4. State Agency Contracts and Requests for Exceptions.

(a) Other Contracts. A state agency, required to participate in contract travel services, shall not enter into a contract for travel services without prior approval of TBPC. TBPC shall consider whether the proposed contract offers the best value for the State and the impact of the proposed contract on existing travel service contracts. A state agency may request TBPC to establish contract services with a particular contractor.

(b) Requests for Additional Exceptions. A state agency shall make a written request to TBPC for additional exceptions, not provided in §125.3 of this subchapter, when the agency offers a reasonable justification for the need for the exception. Additional exceptions may not be granted for longer than the term of existing contracts.

§125.5. State Agency Travel Coordinators.

(a) State agencies shall designate an employee as the travel coordinator, who shall serve as the single point of contact between the TBPC travel management program and the agency for disseminating and collecting travel data and information. State agencies shall provide TBPC with the travel coordinator's name, telephone number, e-mail address, mobile telephone number and other requested and relevant contact information.

(b) State agencies, in cooperation with TBPC, shall provide training to travel coordinators to ensure that:

(1) agency employees receive current travel information;

(2) contract travel services are used in accordance with this subchapter;

(3) travel data reports are submitted in compliance with this subchapter;

(4) agency travel activity is monitored for compliance with this subchapter and other applicable laws and rules; and

(5) complaints, concerns or other information relevant to achieving the efficient and economical travel services for the state are reported to TBPC.

(c) State agencies shall cooperate with TBPC by allowing travel coordinators to participate in travel advisory, proposal evaluation, education and any other groups needed to assist TBPC in contracting for the most economical, efficient and useful travel services.

§125.6. State Agency Reimbursement and Reporting.

(a) State agency officials and employees shall adhere to applicable laws and the regulations and guidelines of the Comptroller of the State of Texas governing travel vouchers.

(b) Reimbursement for Travel Expenses. State agencies shall not approve and the Comptroller shall not pay travel vouchers for services at rates higher than contract rates, unless an exception in §125.3 or §125.4 applies. Travel vouchers submitted for reimbursement shall indicate the claimed exception in a manner prescribed by the Comptroller.

(c) Audits. The Comptroller may conduct pre-payment and post-payment audits of travel reimbursement requests; the audits may include a review of the propriety of claimed exceptions from the use of contract travel services.

(d) False Claims for Reimbursement. All claims for travel reimbursement are subject to the Government Code §403.071 relating to claims and available money. Any person who knowingly makes a false claim against the State is subject to the penalties in Government Code §403.071(f) and other applicable laws.

(e) Monthly reporting. The reports required by this subsection are for those travel services not charged to a state travel credit card.

(1) State agencies shall report the expenditures, as the total dollars spent, and activities, as the total number of trips and days of rental or lodging, relating to travel services as follows:

(A) Air, bus and rail travel: total dollar spend and total number of trips:

(B) Rental car: total dollar spend, total number of trips, and total rental days;

(C) Hotel/lodging: total dollar spend, total lodging trips; total number of nights;

(D) Travel reservation and booking fees: total dollar spend and total number of reservations.

(2) Travel reports shall be submitted to TBPC's Procurement Policy and Strategy Program on or before the 28th day following the reporting month.

(3) Travel reports shall be submitted on a compact or floppy disc in Excel format via United States Postal Service or e-mail. TBPC may also adopt other reporting methods, including web based reporting.

§125.7. Procuring Travel Agency and Other Travel Related Services.

(a) This section describes the authorized methods of procurement for travel services and the specific methods for travel agency contracts.

(b) Travel Agency Contract Structure. TBPC's travel agency contracts shall contain a clear statement of the services provided and the cost associated with each service. The contracts shall also contain descriptions of other ancillary services and any other provisions necessary for the convenience of the State.

(c) Solicitation and Evaluation Procedures for Travel Agency Contracts.

(1) TBPC is not required to competitively bid travel agency contracts.

(2) TBPC may negotiate contracts for travel agency services.

(3) TBPC shall solicit private sector entities to participate in negotiated contracts through effective and efficient means that ensure the best value for the State.

(4) TBPC shall consider the following criteria when evaluating proposed travel agency services:

(A) quantity of services;

(B) quality of services;

(C) price; and

(D) any other terms or conditions required to provide the overall best value for the State.

(d) Other Contracts. TBPC may use authorized competitive or negotiated procedures for procuring travel services. TBPC shall solicit, evaluate and award contracts for travel services in a manner that achieves the best overall value for the State.

§125.8. State Travel Credit Cards.

(a) State Credit Card. State agencies, officials and employees shall use state travel credit cards to purchase contract and non-contract

travel services. Contract travel services for airfare shall be charged to state travel credit cards. Contract and non-contract travel services for lodging, rental vehicles and other necessary travel expenses shall be charged to state travel credit cards, when feasible; purchases by other methods shall be reported monthly pursuant to §125.6(e).

(b) Eligibility. Any entity eligible to use contract travel services is also eligible to obtain state travel credit cards. State credit cards may be used only for official state business and may be issued to individuals and state agencies.

(c) State Travel Credit Cards Issued to Individuals. State agency employees should be issued a state travel credit card when the employee is expected to take at least three trips or spend at least $500 per fiscal year for official state travel business. State agencies may, at their discretion, approve the issuance of the cards to any employee.

(d) State agencies shall ensure that:

(1) state travel credit cards are cancelled upon the employee's termination of employment;

(2) state travel credit cards are cancelled when the employee fails to timely pay the charges, uses the card for personal transactions, or any other misuse of the credit card; and

(3) individuals who are issued state travel credit cards understand that payment of charges on state travel credit cards is the sole responsibility of the individual and that the state shall not be responsible for the charges or for nonpayment by the employee.

(e) Individual Billing. State travel credit cards issued to individuals shall be billed directly to the individual who may obtain reimbursement through properly submitted state travel vouchers that comply with this subchapter and the rules and guidelines of the Comptroller. Other individuals eligible to use state travel credit cards shall comply with the reimbursement rules and procedures of their governing entity.

(f) Centralized Billing. A state travel credit card issued to an eligible entity shall be billed to that entity which may receive reimbursement pursuant to applicable statutes and rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505333
Ingrid K. Hansen
General Counsel
Texas Building and Procurement Commission
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-7829

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SUBCHAPTER B. STATE VEHICLE FLEET MANAGEMENT

1 TAC §125.40

The Texas Building and Procurement Commission (TBPC) adopts new §125.40, concerning definitions, without changes to the proposed text as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6352).

The new section contains definitions, previously located in Chapter 125, Subchapter A, §125.2. The new section will separate the travel management definitions from the vehicle fleet management definitions for better organization and clarity.

No comments were received regarding the proposed section.

The new section is adopted under the authority of Texas Government Code, §2171.1045 which provides the TBPC with the authority to promulgate rules relating to the assignment and use of agency vehicles.

The following code is affected by this section: Texas Government Code, §2171.1045.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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PART 9. STATE AIRCRAFT POOLING BOARD

CHAPTER 181. GENERAL PROVISIONS

1 TAC §§181.1 - 181.9, 181.11 - 181.13, 181.15

The Texas Department of Transportation (department) adopts the repeal of Title 1, Chapter 181, §§181.1 - 181.9, 181.11 - 181.13, and 181.15, concerning general provisions. The repeal is adopted without changes to the proposal as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5461) and will not be republished.

EXPLANATION OF THE ADOPTED REPEAL

House Bill 2702, 79th Legislature, Regular Session, 2005, abolished the State Aircraft Pooling Board (board) and transferred all powers, duties, obligations, rights, contracts, bonds, appropriations, records, and real or personal property of the board to the department. House Bill 2702 also provided that a rule of the board continues in effect as a rule of the department until superseded by an act of the department.

Sections 181.1 - 181.9 prescribe rules concerning the governing body of the board. Due to the abolishment of the board, these sections are no longer needed.

Section 181.11, concerning charges for public records, is no longer necessary. The department has rules governing the charges for public records that will apply to records relating to the functions of the board that were transferred to the department.

Section 181.12, concerning certain fuel and maintenance contracts, does not reflect current practices, and governs issues that should be addressed contractually and not through rulemaking.

Section 181.13, concerning Historically Underutilized Business Contracts and Services, is no longer necessary. The subject is addressed by current department rules governing historically underutilized businesses.

Section 181.15, concerning priority scheduling, provides that statewide elected officials, upon giving 12-hour advance notice to the scheduling office, shall be given priority in the scheduling of aircraft. Government Code, §2205.038(d), requires the department to give a statewide elected official priority in the scheduling of aircraft. It further provides that the department by rule may require a 12-hour notice by the official to obtain priority. The department does not believe that it is necessary to require 12-hour advance notice, and therefore, §181.15 is not necessary.

COMMENTS

No comments on the proposed repeal were received.

STATUTORY AUTHORITY

The repeal is adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: Government Code, Chapter 2205.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505349
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State Aircraft Pooling Board
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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CHAPTER 183. RULEMAKING PROCEDURE

1 TAC §§183.1 - 183.4

The Texas Department of Transportation (department) adopts the repeal of Title 1, Chapter 183, §§183.1 - 183.4, concerning rulemaking procedure. The repeal is adopted without changes to the proposal as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5462) and will not be republished.

EXPLANATION OF THE ADOPTED REPEAL

House Bill 2702, 79th Legislature, Regular Session, 2005, abolished the State Aircraft Pooling Board (board) and transferred all powers, duties, obligations, rights, contracts, bonds, appropriations, records, and real or personal property of the board to the department. House Bill 2702 also provided that a rule of the board continues in effect as a rule of the department until superseded by an act of the department.

The department adopts the repeal of Title 1, Chapter 183, §§183.1 - 183.4, which governs the rulemaking process, including the processing of petitions for rulemaking, for the board. Due to the abolishment of the board, these rules are no longer necessary.

COMMENTS

No comments on the proposed repeal were received.

STATUTORY AUTHORITY

The repeal is adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE: Government Code, Chapter 2205.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200505350
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Effective date: December 8, 2005
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PART 12. COMMISSION ON STATE EMERGENCY COMMUNICATIONS

CHAPTER 251. REGIONAL PLANS--STANDARDS

1 TAC §251.1

The Commission on State Emergency Communications (CSEC) adopts amendments to §251.1, regarding regional strategic plans for 9-1-1 service, without changes to the proposed text as published in the August 5, 2005, issue of the *Texas Register* (30 TexReg 4393).

As amended, §251.1 includes criteria to accommodate Voice over Internet Protocol telephony service, is more streamlined as part of the development of a related Program Policy Statement, and deletes the reference to Mobile Public Safety Answering Points that are no longer applicable. This section is adopted as part of Rule Review of Chapter 251 pursuant to Texas Government Code §2001.039. The rule continues to be essential to the CSEC's operations and per statutory authority.

There were no comments received on CSEC's proposed amendments to the rule.

The amendment is adopted under the authority of the Texas Health and Safety Code, Chapter 771, §§771.051, 771.055, 771.056, 771.057, and 771.075; and Title 1 Texas Administrative Code, Part 12, Chapter 251, Regional Plan Standards, which provide CSEC with the authority to plan, develop, provide provisions for, and enhance the effectiveness and efficiency of 9-1-1 service.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505396
Paul Mallett
Executive Director
Commission on State Emergency Communications
Effective date: December 11, 2005
Proposal publication date: August 5, 2005
For further information, please call: (512) 305-6933

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CHAPTER 254. POISON CONTROL CENTERS

1 TAC §254.1

The Commission on State Emergency Communications (CSEC) adopts new Chapter 254 and §254.1, concerning operations and funding of Poison Control Centers (PCCs), without changes to the proposed text as published in the August 5, 2005, issue of the *Texas Register* (30 TexReg 4393).

CSEC is required by statute to jointly adopt rules regarding PCCs with the Texas Department of Health (TDH, now known as the Texas Department of State Health Services). TDH has repealed and replaced its rules regarding the PCCs (25 TAC §5.51 and §5.52). CSEC's published rule mirrors the intent and the language of the TDH rules.

There were no comments received on CSEC's proposed new chapter or rule.

The new Chapter and rule are adopted under Texas Health and Safety Code, Chapter 777, §777.001(b) and §777.009(b), which require CSEC and TDH to jointly adopt rules regarding PCCs.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505397
Paul Mallett
Executive Director
Commission on State Emergency Communications
Effective date: December 11, 2005
Proposal publication date: August 5, 2005
For further information, please call: (512) 305-6933

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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 19. QUARANTINES AND NOXIOUS PLANTS

SUBCHAPTER Q. SAPOTE FRUIT FLY QUARANTINE

4 TAC §19.172, §19.175

The Texas Department of Agriculture (the department) adopts amendments to §19.172 and §19.175, concerning a quarantine for the sapote fruit fly, *Anastrepha serpentina* (Wiedemann), without changes to the proposal published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6353).

The amendments to §19.172 are adopted to remove the quarantined infested areas and the core areas listed in the sapote fruit fly quarantine to make the rule consistent with the department's declaration regarding the sapote fruit fly published in the July 18, 2003, issue of the *Texas Register*, to increase the number of adult sapote fruit flies required to declare a quarantined infested area from two adults to five, and to change the radius from 4.5 miles to 5 to accurately describe a radius of the 81 square mile area. Recently, the Animal and Plant Health Inspection Service of the United States Department of Agriculture and departments of agriculture of the United States citrus-producing states agreed that relaxing the trigger from two adults to five to designate a quarantined infested area would be biologically acceptable and also would not significantly increase the pest introduction risk. The amendment to §19.175 updates the date referenced for the Texas Valley Mexican Fruit Fly Protocol. The amendments will also eliminate the confusion about the current quarantined area and potential new quarantined areas.

No comments were received on the proposal.

The amendments are adopted under the Texas Agriculture Code, §71.001, which authorizes the department to establish a quarantine for an infested area against an in-state pest if it determines that the pest is dangerous and is not widely distributed in this state; and §71.007, which authorizes the department to adopt rules as necessary to protect agricultural and horticultural interests, including rules to provide for specific treatment of a grove or orchard or of infested or infected plants, plant products, or substances.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505398
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Texas Department of Agriculture
Effective date: December 11, 2005
Proposal publication date: October 7, 2005
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TITLE 10. COMMUNITY DEVELOPMENT

PART 1. TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

CHAPTER 51. HOUSING TRUST FUND RULES

10 TAC §§51.1 - 51.11, 51.13

The Texas Department of Housing and Community Affairs (the Department) adopts, without changes, the repeal of §§51.1 - 51.11 and §51.13, concerning the 2006 Housing Trust Fund Rules, as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5209).

The sections are being repealed in order to enact new sections conforming to Chapter 2306 of the Texas Government Code, which governs the administration of the Housing Trust Fund.

Public hearings were held across the state between September 26 and October 7, 2005 to receive input on the proposal. In addition to publishing the rules in the *Texas Register*, a copy of the rules were published on the Department's web site and made available upon request to the public. The Department received no written comments.

The repeal is adopted pursuant to the authority of the Texas Government Code, Chapter 2306.

No other code, article or statute is affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 14, 2005.

TRD-200505235
Edwina Carrington
Executive Director
Texas Department of Housing and Community Affairs
Effective date: December 4, 2005
Proposal publication date: September 2, 2005
For further information, please call: (512) 475-4595

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10 TAC §§51.1 - 51.11

The Texas Department of Housing and Community Affairs (the Department) adopts §§51.1 - 51.11, concerning the 2006 Housing Trust Fund (HTF) Rules. The new sections are adopted without changes to the proposed text as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5209).

These sections are adopted, in order to improve the operation of the program, respond to public input, and improve consistency with other Department rules.

Public hearings were held across the state between September 26 and October 7, 2005 to receive input on the proposal. In addition to publishing the rules in the *Texas Register*, a copy of the rules were published on the Department's web site and made available upon request to the public. The Department held thirteen public hearings across the state to gather feedback on the proposed new sections. The Department received no written comments.

The scope of the public comment concerning the Housing Trust Fund pertains to the following sections:

General: Capacity Building Program (2, 3)

Speakers noted that the current program guidelines for Capacity Building are focused too much on development related activities, instead of acting to bridge the administrative and technical capacity needs for nonprofits. The program should have stronger performance outcome measure tracking so that progress can be shown in a qualitative manner, instead of through unit production. Match requirements in this year's program made it difficult for smaller communities to compete in the program.

Department Response: The Department is committed to ensuring that Housing Trust Funds are utilized to maximize the benefit to the citizens of Texas and our applicants. The Capacity Building program will continue to seek new ways to assist developing nonprofits, while at the same time utilizing this limited resource to have a measurable impact. No change is recommended.

Board Response: Accepted Department Response.

§51.7, Criteria for Funding (1), Pages 11 and 12 of 14

A comment was made regarding the percentage of funding from HTF to be spent in rural areas. The respondent was concerned that rural communities were not able to compete against urban areas in competitive application rounds for Housing Trust Funds.

Department Response: Staff continues to find ways to support rural development activities. The Department's statutory requirements ensure that funding is available to rural applicants in each of the 13 state service regions. It should be noted that the Department's HOME funds are targeted almost exclusively to rural areas, and provide a significant funding source for nonprofits, for profits and local governments. No change is recommended.

Board Response: Department's response accepted.

List of Commenters

Number 1: Crossroads Housing Development Corp.

Number 2: Latino Education Project

Number 3: Accessible Communities Inc.

The new sections are adopted pursuant to the authority of the Texas Government Code, Chapter 2306.

No other code, articles or statutes are affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 14, 2005.

TRD-200505234
Edwina Carrington
Executive Director
Texas Department of Housing and Community Affairs
Effective date: December 4, 2005
Proposal publication date: September 2, 2005
For further information, please call: (512) 475-4595

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PART 7. TEXAS RESIDENTIAL CONSTRUCTION COMMISSION

CHAPTER 313. STATE-SPONSORED INSPECTION AND DISPUTE RESOLUTION PROCESS (SIRP)

10 TAC §313.27

The Texas Residential Construction Commission ("commission") adopts new §313.27, concerning post-SIRP correspondence, relating to correspondence between builders and homeowners after the state-sponsored inspection and dispute resolution process (SIRP) has concluded.

The rule is adopted without changes to the text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5462).

The adopted new section sets forth the requirement that builders provide the commission with post-SIRP information relating to settlement or other dispute resolution activities.

The new section provides for the commission to create a form that builders who participate in an SIRP are required to file with the commission to keep the commission abreast of resolution activities after the SIRP final nonappealable report has been issued. Failure to comply with the new proposed section may result in denial of registration renewal under Property Code Chapter 416.

The new section provides a mechanism for the commission to keep abreast of the number of SIRPs that result in repairs or settlements of post-construction defect disputes. By tracking the information provided on the form, the commission will be able to assess the business practices of the builder and to determine if the SIRP accomplishes its stated goals.

The commission received no comments on the new rule.

The new section is adopted under Property Code §408.001, which provides generally authority for the commission to adopt rules necessary for the implementation of Title 16 and Property Code, ch. 416, which requires the commission to consider an applicant's honest, integrity and trustworthiness when determining the applicant's eligibility for registration as a builder or remodeler.

The new section is adopted to implement Property Code §408.001 and chapter 416. No other statutes are affected by this new rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 17, 2005.

TRD-200505319
Susan K. Durso
General Counsel
Texas Residential Construction Commission
Effective date: December 7, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-2886

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER R. CUSTOMER PROTECTION RULES FOR RETAIL ELECTRIC SERVICE

16 TAC §25.472

The Public Utility Commission of Texas (commission) adopts an amendment to §25.472(b)(3), relating to Privacy of Customer Information without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5463).

The proposed amendment deletes the following language from subsection (b)(3) of the rule: "For industrial and commercial customers, the TDU (Transmission and Distribution Utility) or REP (Retail Electric Provider) shall not release any information of a prior occupant of the premise, if a prior occupant has designated the information as competitively sensitive." This rule is a competition rule subject to judicial review as specified in §39.001(e) of the Public Utility Regulatory Act, Texas Utilities Code Annotated, Title II (Vernon 1998 & Supp. 2004-2005) (PURA). This amendment is adopted under Project Number 30769.

The commission received comments on the proposed amendment from "Joint Commenters" comprised of AEP Texas Central Company; AEP Texas North Company; CenterPoint Energy Houston Electric, LLC; TXU Electric Delivery Company; Texas-New Mexico Power Company; CPL Retail Energy; Direct Energy; Entergy Solutions Ltd.; First Choice Power; Gexa Energy; Green Mountain Energy Company; Reliant Energy; Stream Energy; TXU Energy; WTU Retail Energy; Competitive Assets on behalf of its undisclosed retail electric provider clients; and the Alliance for Retail Markets, consisting of APS Energy Services, Constellation New Energy, Inc., Direct Energy, Entergy Solutions Ltd., Green Mountain Energy Company, Hino Electric, Strategic Energy, Stream Energy and Utility Choice Electric. The commission also received comments on the proposed amendment from Texas Industrial Energy Consumers (TIEC).

Joint Commenters stated that they agreed with Staff's recommendation that the language mentioned above should be deleted from P.U.C. SUBST. R. §25.472(b)(3). Joint Commenters stated that market meetings were initiated at the direction of the Retail Market Subcommittee to identify a means of complying with the existing rule and to identify additional options. Despite numerous meetings, the group could only reach one recommendation which would comply with the rule. This recommendation would require transactional and process changes for each market participant, including the Electric Reliability Council of Texas, Inc. (ERCOT) and would be unduly costly to those parties. Joint Commenters stated that the TX SET working group deemed this option financially and technically excessive and that the Joint Commenters agreed with that conclusion.

Joint Commenters stated that to date, no market participant or customer has requested that historical data be held as competitively sensitive, and therefore it appears that it would be in the best interest of consumers and the Texas market to amend the rule to avoid requiring market participants to expend the financial capital and resources necessary to implement the rule.

TIEC stated that the proposed rule change would delete the current requirement that was put in place to provide continued

protection for customer-specific usage after a customer vacated the premises. TIEC stated that this issue appears to typically arise when one business sells a premise or facility to another business. TIEC stated that while they originally supported this provision, it has become apparent that there is no readily available mechanism by which ERCOT can protect a prior customer's data. TIEC also stated that it has become apparent that most commercial and industrial customers are in a good position to protect the confidentiality of their usage data contractually.

Commission Response

The commission agrees with the comments of both Joint Commenters and TIEC. As no commenter requested changes to the proposed amendment, the commission will make no changes to the proposed text as published.

TIEC stressed that the confidentiality afforded customer-specific usage data be maintained since release of such data could cause tremendous competitive harm. Therefore, TIEC requested that the commission be clear that by removing the language noted above, the commission is not reducing the protections afforded such data. Additionally, TIEC asked that if the protection that is being removed ever becomes necessary, that the commission consider other mechanisms to ensure that competitively sensitive customer data is protected.

Commission Response

The commission acknowledges the importance of the confidentiality of customer-specific usage data and finds that the removal of the language noted above does not reduce the protections afforded to such data. The commission agrees that should the provision that is being removed ever prove to be necessary for the protection of competitively sensitive customer-specific data, the commission will consider requiring the development of a mechanism or mechanisms to ensure such data is protected.

This amendment is adopted under PURA §14.002 which provides the commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction. The commission also proposes this amendment pursuant to PURA §39.101, which grants the commission authority to establish protections for retail customers.

Cross Reference to Statutes: PURA §14.002 and §39.101.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505376
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 936-7223

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PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 59. CONTINUING EDUCATION REQUIREMENTS

16 TAC §59.3

The Texas Department of Licensing and Regulation ("Department") adopts amendments to 16 Texas Administrative Code, §59.3 regarding continuing education requirements as published in the September 16, 2005, issue of the *Texas Register* (30 TexReg 5892) without changes. The adopted rule will not be republished.

Texas Occupations Code, §51.405 requires the Texas Commission of Licensing and Regulation ("Commission") to recognize, prepare, or administer continuing education programs for license holders. In response to this legislative mandate, the Commission adopted rules at 16 Texas Administrative Code, Chapter 59 to establish general requirements for continuing education providers and courses.

The amendments to §59.3 add the following programs to the coverage of Chapter 59: cosmetologists, licensed court interpreters, property tax consultants, and registered accessibility specialists. The amendments are necessary because the Commission is adopting, or intends to adopt, rules with continuing education requirements that are specific to each of those programs. Therefore, it is necessary to have the general provisions of Chapter 59 apply to those programs.

These amendments will allow for providers of continuing education for those programs to begin registering with the Department and, once a specific continuing education rule is in place for the particular program, obtaining approval for courses. The provisions of Chapter 59, including fee provisions, will apply to the programs. Continuing education requirements that are specific to each of the programs are, or will be, contained in the rules for the respective programs. This rule amendment is necessary to implement Texas Occupations Code, §51.405 with respect to the referenced programs.

The Department drafted and distributed the proposed rule to persons internal and external to the agency. The proposal was published in the *Texas Register* on September 16, 2005. The comment period closed on October 17, 2005. No public comments were received regarding the proposed amendments.

The amendments are adopted under Texas Occupations Code, Chapter 51, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department. In addition, this rule implements Texas Occupations Code, §1152.204(a), concerning continuing education for property tax consultants, and Texas Occupations Code, §1602.354, concerning continuing education for cosmetologists.

The statutory provisions affected by the adoption are those set forth in Texas Occupations Code, Chapters 51, 1152, 1602, and 1603, and Texas Government Code, Chapters 57 and 469. No other statutes, articles, or codes are affected by the adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505356

William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Effective date: December 8, 2005
Proposal publication date: September 16, 2005
For further information, please call: (512) 463-7348

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CHAPTER 65. BOILER DIVISION

16 TAC §§65.10, 65.20, 65.50, 65.60, 65.70, 65.100

The Texas Department of Licensing and Regulation ("Department") adopt amendments to existing rules at 16 Texas Administrative Code, §§65.10, 65.20, 65.50, 65.60, 65.70, regarding the boiler program as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6355), without changes and will not be republished. Section 65.100 is adopted with changes from the rule as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6355).

These amendments are necessary to clarify, reorganize, and update requirements for boilers. The amendments are needed to provide better organization for the rules and bring rules more into line with ASME (American Society of Mechanical Engineers) Code and NBIC (National Board Inspection Code) requirements. These national codes provide safety standards for the boiler industry. The amendments relocate provisions to make the rules easier to use, add definitions and metric conversion values for greater clarity, and make technical corrections. In addition, the amendments incorporate matters that have been the subject of variance requests and so will eliminate the need for Department staff to process these particular kinds of variance requests in the future.

An amendment to §65.70(f)(2) removed mandated top and side boiler clearance requirements and replaced them with the manufacturer's recommended side clearances. This change should ease the burden of compliance with the rule by deferring to manufacturer's specifications, rather than stating specific requirements in the rule. Subsection (i) was added to reflect requirements for restamping and name plate replacement. Subsection (j) was added to clarify the requirements for "HLW" stamped boilers with reference to hot water heating systems. Subsection (k) was added to reflect new requirements for modular boiler installations. Subsection (l) was added to reflect and to clarify the requirements for multiple pressure steam generators. Subsection (m) was added to reflect and to clarify the requirements for stacked boilers installations.

Provisions of §65.100(e)(4) and (5) were reworded to more accurately reflect the requirements of the ASME Code, Section I, Part PEB; in subsection (e)(7) language was added to clarify the requirements for the internal inspection of electric boilers; in subsection (f) language was added to clarify requirements that pertain only to extensions; in subsection (g)(6)(C) language was added to clarify possible accesses for entry; new subsection (g)(8) was added to state boiler external piping requirements for power boilers; new subsection (h)(8)(C) was added to state entry requirements for unfired steam boilers; and new subsection (i)(9)(C) was added to state entry requirements for process steam generators.

Additional changes in §65.100(n)(1), (2), (3), (5) added the word "pressure" to the section title and in the rule text for clarification; language was revised in §65.100(n)(4) to more accurately describe the NBIC and jurisdictional requirements; and in §65.100(n)(5)(B) the language "and addenda" was added to the end of the paragraph for clarification.

A change has been made from the rules as proposed. The text of proposed §65.100(k), concerning authority to set and seal safety appliances, has been moved to subsection (o), and the text of proposed subsection (o), concerning heating boilers, has been moved to subsection (k). This change makes for a more logical organization of the rules. Because this is not a substantive change, it is not necessary to republish the rules for public comment.

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposal was published in the *Texas Register* on October 7, 2005. The comment period closed on November 7, 2005. No public comments were received regarding the proposed amendments. The Board of Boiler Rules, which is an advisory body to the Commission, has recommended adoption of the amendments.

The amendments are adopted under Texas Health and Safety Code, Chapter 755 and Texas Occupations Code, Chapter 51, which authorizes the Commission of Licensing and Regulation to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department. In particular, these rule amendments are adopted under Texas Health and Safety Code, §755.032, which authorizes the Commission to adopt rules, in accordance with standard boiler usage, for the construction, inspection, installation, use, maintenance, repair, alteration, and operation of boilers.

The statutory provisions affected by the adoption are those set forth in Texas Health and Safety Code, Chapter 755 and Texas Occupations Code, Chapter 51. No other statutes, articles, or codes are affected by the adoption.

§65.100. Technical Requirements.

(a) Conditions not covered by rules.

(1) Any owner or operator of boilers or any deputy inspector, authorized inspector, or interested party may submit in writing an inquiry to the executive director for an opinion or clarification.

(2) All conditions not specifically covered by these requirements shall be treated as new installations or be referred to the chief inspector for instruction.

(b) General safety.

(1) If, in the judgment of the inspector, a boiler is unsafe for operation at the pressure previously approved, the pressure shall be reduced and proper repair made, or the boiler shall be removed from service.

(2) Before internal access is made to a boiler by an inspector, the inspector shall deem the environment within the boiler to be safe for occupancy.

(c) Ventilation.

(1) The boiler room must have an adequate and uninterrupted air supply to assure proper combustion and ventilation.

(2) The combustion and ventilation air may be supplied by either an unobstructed opening or by power ventilators or fans.

(3) The opening shall be sized on the basis of one square inch (645 square millimeters) of free area for each 2,000 Btu/hour (.586 kilowatts) input of the combined burners located in the boiler room.

(4) The power ventilator or fans shall be sized on the basis of 0.2 cfm. (5.6 liters per minute) for each 1,000 Btu/hour (.29 kilowatts) fuel input for the combined burners located in the boiler room.

(5) The boiler and the fans shall be interlocked so that the burners will not operate unless an adequate number of fans are in operation.

(d) Location of discharge outlets. The discharge of safety valves and safety relief valves, blowdown pipes, and other outlets shall be located to prevent injury to personnel.

(e) Electric steam boilers.

(1) A cable at least as large as one of the incoming power lines to the generator shall be provided for grounding the generator shell. This cable shall be permanently fastened on some part of the generator and shall be grounded in an approved manner.

(2) A suitable screen or guard shall be provided around high-voltage bushings, and a sign posted warning of high voltage. This screen or guard shall be so located that it will be impossible for anyone working around the generator to accidentally come in contact with the high voltage circuit.

(3) In electric boilers of the submerged-electrode type, the water gage glass shall be located to indicate the water levels both at start-up and under maximum load conditions as established by the manufacturer.

(4) Electric boilers of the resistance-element type shall have at least one gage glass. The lowest visible water level in the gage glass shall be at least 1 inch (25 millimeters) above the lowest permissible water level as determined by the manufacturer. Each boiler of this type shall be equipped with an automatic low-water cutoff to cut off the power supply before the surface of the water falls below the visible level in the gage glass.

(5) Tubular gage glasses on electric boilers shall be equipped with protective rods or shields.

(6) The minimum safety valve or safety relief valve relieving capacity for electric boilers shall be 3 1/2 pounds (24 kilopascals) of steam per hour per kilowatt input.

(7) All electric boilers shall be internally examined through the electric heating element, removable cover, inspection opening or handhole as construction allows.

(f) Atmospheric vents, gas vents, bleed or relief lines for power boilers, unfired steam boilers and process steam generators with supplemental firing (extensions only, where applicable).

(1) Gas pressure regulators not incorporating integral vent limiters, and all other gas train components requiring atmospheric air pressure to balance a diaphragm or other similar device, shall be provided with a connection for a vent line. These lines shall be sized in accordance with the component manufacturer's instructions. The vent or relief line shall be at least the same size as the vent outlet of the device.

(A) Where there is more than one gas pressure regulator at a location, each gas pressure regulator shall have a separate vent. The vent lines may be manifolded in accordance with accepted engineering practices to minimize back pressure in the event of a diaphragm failure (see paragraphs (2) and (3) following).

(B) A gas pressure regulator shall not be vented into the boiler flue or exhaust system.

(2) Atmospheric vent lines, when manifolded, shall be connected into a common atmospheric vent line having a cross-sectional area not less than the area of the largest vent line plus 50% of the areas of the additional vent lines.

(3) Atmospheric vent lines shall not be connected to any common or manifolded gas vent, bleed, or relief lines.

(4) Gas pressure relief valves may discharge into common manifolding only with other gas vent, bleed, or relief lines. When manifolded, the common vent line shall have a cross-sectional area not less than the area of the largest vent line plus 50% of the areas of the additional vent lines.

(5) Vent and relief lines shall be piped to the outdoors at a safe point of discharge so there is no possibility of discharged gas being drawn into the air intake, ventilating system, or openings of any structure or piece of equipment and shall extend sufficiently above any structure so that gaseous discharge does not present a fire hazard. A means shall be provided at the terminating point to prevent blockage of the line by foreign material, moisture, or insects.

(g) Power boilers, excluding unfired steam boilers and process steam generators.

(1) Safety valves and safety relief valves.

(A) The use of weighted-lever safety valves, or safety valves having either the seat or disk of cast iron, is prohibited.

(B) Each boiler shall have at least one safety valve and, if it has more than 500 square feet (47 square meters) of water heating surface or has electric power input more than 1,100 kilowatts, it shall have two or more safety valves.

(C) The valve or valves shall be connected to the boiler, independent of any other steam connection, and attached as close as practicable to the boiler without unnecessary intervening pipe or fittings.

(D) No valve(s) of any description shall be placed between the required safety valve or safety relief valve or valves and the boiler, nor in the discharge pipe between the safety valve or safety relief valve or valves and the atmosphere. When a discharge pipe is used, it shall be at least full size of the safety valve discharge and fitted with an open drain to prevent water lodging in the upper part of the safety valve or discharge pipe. When an elbow is placed on a safety valve discharge pipe, it shall be located close to the safety valve outlet. The discharge pipe shall be securely anchored and supported. In the event multiple safety valves discharge into a common pipe, the discharge pipe shall be sized in accordance with ASME Code, Section I, PG-71. All safety valve or safety relief valve discharges shall be located or piped to a safe point of discharge clear from walkways or platforms.

(E) The safety valve capacity of each boiler must allow the safety valve or valves to discharge all the steam that can be generated by the boiler without allowing the pressure to rise more than 6.0% above the highest pressure to which any valve is set, and to no more than 6.0% above the maximum allowable working pressure. For forced-flow steam generators with no fixed steam and waterline, power-actuated relieving valves may be used in accordance with ASME Code, Section I, PG-67.

(F) One or more safety valves on every boiler shall be set at or below the maximum allowable working pressure. The remaining valve(s) may be set within a range of 3.0% above the maximum allowable working pressure, but the range of setting of all the safety valves on a boiler shall not exceed 10% of the highest pressure to which any valve is set.

(G) When two or more boilers, operating at different pressures and safety valve settings, are interconnected, the lower pres-

sure boilers or interconnected piping shall be equipped with safety valves of sufficient capacity to prevent overpressure, considering the maximum generating capacity of all boilers.

(H) In those cases where the boiler is supplied with feedwater directly from water mains without the use of feeding apparatus (not to include return traps), no safety valve shall be set at a pressure higher than 94% of the lowest pressure obtained in the supply main feeding the boilers.

(2) Feedwater supply.

(A) Each boiler shall have a feedwater supply, which will permit it to be fed at any time while under pressure.

(B) A boiler having more than 500 square feet (47 square meters) of water heating surface shall have at least two means of feeding, one of which should be a pump, injector, or inspirator. A source of feed directly from water mains at a pressure of at least 6.0% greater than the set pressure of the safety valve with the highest setting may be considered as one of the means of feeding. Boilers fired by gaseous, liquid, or solid fuel in suspension may be equipped with a single means of feeding water, provided means are furnished for the immediate shutoff of heat input if the feedwater is interrupted.

(C) Feedwater shall not be discharged close to riveted joints of shell or furnace sheets or directly against surfaces exposed to products of combustion or to direct radiation from the fire.

(D) Feedwater piping to the boiler shall be provided with a check valve near the boiler and a stop valve or cock between the check valve and the boiler. When two or more boilers are fed from a common source there shall also be a stop valve on the branch to each boiler between the check valve and the source of supply. Whenever a globe valve is used on the feedwater piping, the inlet shall be under the disk of the valve.

(E) In all cases where returns are fed back to the boiler by gravity, there shall be a check valve and stop valve in each return line, the stop valve to be placed between boiler and the check valve, and both shall be located as close to the boiler as is practicable. It is recommended that no stop valve be placed in the supply and return pipe connections of a single boiler installation.

(F) Where deaerating heaters are not used, it is recommended that the temperature of the feedwater be not less than 120 degrees Fahrenheit (49 degrees Celsius) to avoid the possibility of setting up localized stress. Where deaerating heaters are used, it is recommended that the minimum feedwater temperature be not less than 215 degrees Fahrenheit (102 degrees Celsius) so that dissolved gases may be thoroughly released.

(3) Water level indicators.

(A) Each boiler, except forced-flow steam generators with no fixed steam and waterline, and high temperature water boilers of the forced circulation type that have no steam and waterline, shall have at least one water gage glass.

(B) Except for electric boilers of the electrode type, boilers with a maximum allowable working pressure (MAWP) over 400 psig (three megapascals) shall be provided with two water gage glasses, which may be connected to a single water column or connected directly to the drum.

(C) Two independent remote level indicators may be provided instead of one of the two required gage glasses for boiler drum water level indication, when the MAWP is above 400 psig (three megapascals). When both remote level indicators are in reliable operation, the remaining gage glass may be shut off, but shall be maintained in serviceable condition.

(D) In all installations where direct visual observations of the water gage glass(es) cannot be made, two remote level indicators shall be provided at operational level.

(E) The gage glass cock connections shall not be less than 1/2 inch nominal pipe size (diameter nominal 15).

(F) No outlet connections, except for damper regulator, feedwater regulator, drains, steam gages, or apparatus of such form as does not permit the escape of an appreciable amount of steam or water therefrom, shall be placed in the pipes connecting a water column or gage glass to a boiler.

(G) The water column shall be fitted with a drain cock or drain valve of at least 3/4 inch nominal pipe size (diameter nominal 20). The water column blowdown pipe shall not be less than 3/4 inch nominal pipe size (diameter nominal 20) and shall be piped to a safe point of discharge.

(H) Connections from the boiler to remote level indicators shall be at least 3/4 inch nominal pipe size (diameter nominal 20), to and including the isolation valve, and at least 1/2 inch (13 millimeters) OD tubing from the isolation valve to the remote level indicator. These connections shall be completely independent of other connections for any function other than water level indication.

(4) Low-water fuel cutoff and water feeding devices.

(A) All automatically fired steam boilers, except boilers having a constant attendant, who has no other duties while the boiler is in operation, shall be equipped with approved low-water fuel cutoffs. These devices shall be installed in such a manner that they cannot be rendered inoperative by the manipulation of any manual control or regulating apparatus. The low-water fuel cutoff devices shall be tested regularly by lowering the water level in the boiler sufficiently to shut off the fuel supply to the burner when the water level reaches the lowest safe level for operation. The low-water cutoff shall be rated for a pressure and temperature equal to or greater than the maximum allowable working pressure and temperature of the boiler.

(B) When a low-water fuel cutoff and feedwater pump control are combined in a single device, an additional separate low-water fuel cutoff shall be installed. The additional control shall be wired in series electrically with the existing low-water fuel cutoff.

(C) When a low-water fuel cutoff is housed in either the water column or a separate chamber it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the lower-water fuel cutoff device.

(D) If a water feed device is utilized, it shall be constructed to prevent feedwater from entering the boiler through the water column or separate chamber of the low-water fuel cutoff.

(5) Pressure gages.

(A) Each boiler shall have a pressure gage that is easily readable. The dial of the pressure gage shall be graduated to approximately double the pressure at which the safety valve is set, but in no case, less than one and one-half times this pressure. The pressure gage shall be connected to the steam space, to the water column, or its steam connection. A valve or cock shall be placed in the gage connection adjacent to the gage. An additional valve or cock may be located near the boiler providing it is locked or sealed in the open position. No other shutoff valves shall be located between the gage and the boiler.

The pipe connection shall be of ample size and arranged so that it may be cleared by blowing down. For a steam boiler, the gage or connection shall contain a siphon or equivalent device which will develop and maintain a water seal that will prevent steam from entering the gage tube.

(B) Each boiler must have a valved connection at least 1/4 inch nominal pipe size (diameter nominal 8) connected to the steam space for the exclusive purpose of attaching a test gage when the boiler is in service to test the accuracy of the pressure gage.

(6) Stop valves.

(A) Each steam outlet from a boiler (except safety valve connections) shall be fitted with a stop valve located as close as practicable to the boiler.

(B) When a stop valve is located that allows water to accumulate, ample drains shall be provided. The drain shall be piped to a safe location and shall not be discharged on the boiler or its setting.

(C) When boilers provided with manholes or other similar opening that permits access for human occupancy and that are connected to a common steam main, the steam connection from each boiler shall be fitted with two stop valves with an ample drain between them. The discharge of the drain shall be visible to the operator while manipulating the valves and shall be piped clear of the boiler setting. The stop valves shall consist preferably of one automatic nonreturn valve (set next to the boiler) and a second valve of the outside-screw-and-yoke type.

(7) Blowdown connection.

(A) The construction of the setting around each blowdown pipe shall permit free expansion and contraction. These setting openings must be sealed without restricting the movement of the blowdown piping.

(B) All blowdown piping, when exposed to furnace heat, shall be protected by firebrick or other heat-resisting material, and constructed to allow the piping to be inspected readily or easily.

(C) Each boiler shall have a blowdown pipe, fitted with a valve or cock, in direct connection with the lowest water space. The piping shall be run full size without the use of a reducer or bushings and shall not be galvanized. Cocks shall be of gland or guard type and suitable for the pressure allowed. The use of globe valves shall be in accordance with ASME code.

(D) When the maximum allowable working pressure exceeds 100 psig (700 kilopascals), the piping shall be at least schedule 80 steel and shall not be galvanized. Each blowdown pipe shall be provided with two valves or a valve and cock, such valves and cocks shall be adequate for design conditions of the boiler.

(E) All fittings between the boiler and blowdown valve shall be of steel or extra-heavy malleable iron. In case of renewal of blowdown pipe or fittings, they shall be installed in accordance with the requirements of the applicable section of the ASME code.

(F) It is recommended that blowdown tanks be designed, constructed, and installed in accordance with National Board recommended rules for boiler blowoff equipment.

(8) Boiler external piping. All boiler external piping, as referenced in the ASME code, shall be examined for compliance to the boiler's code of construction and shall be documented in the appropriate block on the inspection report.

(h) Unfired steam boilers.

(1) Unfired steam boilers referred to in Section 65.10 are shown in Exhibits 5C and 5D.
Figure 1: 16 TAC §65.100(h)(1)
Figure 2: 16 TAC §65.100(h)(1)

(2) Unfired steam boilers shall be constructed in accordance with the American Society of Mechanical Engineers (ASME), Section I, or ASME, Section VIII, Division 1.

(A) Unfired steam boilers constructed in accordance with ASME Code, Section VIII, Division 1 shall meet the special requirements for unfired steam boilers and shall be stamped with the U symbol stamping including the UB lettering. The limits are defined as the first blinding point, circumferential welded joint, threaded joint, or flanged joint in the piping connected to each vessel in which steam is generated. The safety devices, gages, gage glasses, and similar devices used to perform the functions covered by ASME Code, Section I, PG-59 through PG-61 are included within the Jurisdictional limits as shown in Exhibit 5C.

(B) When the owner/operator elects to construct the unfired steam boiler to ASME Code, Section I, the limits as shown in Exhibit 5D are as defined in Section I of the ASME code.

(3) Safety valves and safety relief valves

(A) The use of weighted-lever safety valves, or safety valves having either the seat or disk of cast iron, is prohibited.

(B) Each ASME Code, Section VIII, Division 1 unfired steam boiler shall have at least one pressure relieving device. Safety valves for ASME, Section VIII, Division 1 unfired steam boilers shall be V or UV stamped. ASME, Section VIII, Division 1 does not require that the relief device be attached directly to the boiler.

(i) The installation of isolation valves between the unfired steam boiler and the safety valve is permitted for systems designed and installed as depicted in Exhibit 5C.

(ii) Full-area stop valves may be installed on the inlet side of a safety valve as shown in Exhibit 5C. A full-area stop valve may be installed on the discharge of the safety valve when connected to a common header. Stop valves shall be car sealed or locked in the open position.

(iii) One or more safety valves on every unfired steam boiler shall be set at or below the maximum allowable working pressure. The remaining valves, if any, shall be set within the range specified and have the capacity required by the applicable ASME code.

(C) Each ASME Code, Section I unfired steam boiler shall have one safety valve and if it has more than 500 square feet (47 square meters) of water heating surface it shall have two or more safety valves. ASME Code, Section I safety valves shall be V stamped.

(i) The valve or valves shall be connected to the boiler, independent of any other steam connection, and attached as close as practicable to the boiler without unnecessary intervening pipe or fittings.

(ii) No valves of any description shall be placed between the required safety valve or safety relief valve or valves and the boiler, nor on the discharge pipe between the safety valve or safety relief valve and the atmosphere.

(iii) The safety valve capacity of each unfired steam boiler must allow the safety valve or valves to discharge all the steam that can be generated by the boiler without allowing the pressure to rise more than 6.0% above the highest pressure to which any valve is set, and to no more than 6.0% above the maximum allowable working pressure.

(D) When a discharge pipe open to the atmosphere is used, it shall be at least full size of the safety valve discharge and fitted with an open drain to prevent water lodging in the upper part of the safety valve or discharge piping. The drain or drains shall be piped to a safe point of discharge. When an elbow or fitting is installed on the discharge pipe it shall be located close to the safety valve outlet. The discharge pipe shall be securely anchored and supported. All safety valve discharges shall be located or piped to a safe point of discharge clear from walkways or platforms.

(E) When two or more unfired steam boilers operating at different pressures and safety valve settings are interconnected, the lower pressure boilers or interconnected piping shall be equipped with safety valves of sufficient capacity to prevent overpressure, considering the maximum generating capacity of all boilers.

(4) Feedwater supply.

(A) Each unfired steam boiler shall have a feedwater supply which will permit it to be fed at any time while under pressure.

(B) Feedwater piping to the unfired steam boiler constructed to ASME Code, Section I shall be provided with a check valve near the boiler and a stop valve or cock between the check valve and the boiler. When two or more boilers are fed from a common source there shall also be a stop valve on the branch to each boiler between the check valve and the source of supply. Whenever a globe valve is used on the feedwater piping, the inlet shall be under the disk of the valve.

(C) Where deaerating heaters are not used, it is recommended that the temperature of the feedwater be not less than 120 degrees Fahrenheit (49 degrees Celsius) to avoid the possibility of setting up localized stress. Where deaerating heaters are used, it is recommended that the minimum feedwater temperature be not less than 215 degrees Fahrenheit (102 degrees Celsius) so that dissolved gases may be thoroughly released.

(5) Water level indicators.

(A) ASME Code, Section I unfired steam boilers with a maximum allowable working pressure (MAWP) of 400 psig (three megapascals) or less shall have at least one gage glass. For a MAWP over 400 psig (three megapascals) shall have two required gage glasses. When two gage glasses are required one of the gage glasses may be replaced by two independent remote level indicators that are maintained in simultaneous operation while the boiler is in service.

(B) Each steam drum of an ASME Code, Section VIII, Division 1 unfired steam boiler, irrespective of pressure and temperature, shall be provided with one direct reading water level indicator (water gage glass) or two independent remote level indicators that are maintained in simultaneous operation while the boiler is in service.

(C) In all installations where direct visual observations of the water gage glass(es) cannot be made, two remote level indicators shall be provided at operational level.

(D) The gage glass cock connections shall not be less than 1/2 inch nominal pipe size (diameter nominal 15).

(E) No outlet connections, except for feedwater regulators, drains, steam gages, or apparatus of such form as does not permit the escape of an appreciable amount of steam or water therefrom, shall be placed in the pipes connecting a water column or gage glass to a boiler.

(F) The water column shall be fitted with a drain cock or drain valve of at least 3/4 inch nominal pipe size (diameter nominal 20). The water column blowdown pipe shall not be less than 3/4 inch nominal pipe size (diameter nominal 20) and shall be piped to a safe point of discharge.

(G) Connections from the unfired steam boiler to remote level indicators shall be at least 3/4 inch nominal pipe size (diameter nominal 20), to and including the isolation valve, and at least 1/2 inch (13 millimeters) OD tubing from the isolation valve to the remote level indicator. These connections shall be completely independent of other connections for any function other than water level indication.

(6) Low-water cutoffs, alarms and feed regulating devices.

(A) The owner/operator is responsible for the design and installation of any low water protection devices as required to prevent damage to the unfired steam boiler. All installed low water cutoffs, alarms and feeding devices shall be designed for pressure and temperature equal or greater than the maximum allowable working pressure of the unfired steam boiler.

(B) When a low-water cutoff, and/or alarm is housed in either the water column or a separate chamber, it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the low-water cutoff and/or alarm device.

(C) Should an unfired steam boiler be installed in a system without a local and constant attendant, and it is not a fail safe design, it shall be provided with a low-water cutoff as required for power boilers.

(7) Pressure gages.

(A) Each unfired steam boiler shall have a pressure gage that is easily readable. The dial of the pressure gage shall be graduated to approximately double the pressure at which the safety valve is set, but in no case, less than one and one-half times this pressure. The pressure gage shall be connected to the steam space, to the water column, or its steam connection. A valve or cock shall be placed in the gage connection adjacent to the gage. An additional valve or cock may be located near the boiler providing it is locked or sealed in the open position. No other shutoff valves shall be located between the gage and the boiler. The pipe connection shall be of ample size and arranged so that it may be cleared by blowing down. The gage or connection shall contain a siphon or equivalent device which will develop and maintain a water seal that will prevent steam from entering the gage tube.

(B) Each unfired steam boiler must have a valved connection at least 1/4 inch nominal pipe size (diameter nominal 8) connected to the steam space for the exclusive purpose of attaching a test gage when the boiler is in service to test the accuracy of the pressure gage.

(8) Stop valves.

(A) Each steam outlet from an ASME Code, Section I unfired steam boiler shall be fitted with a stop valve located as close as practicable to the boiler.

(B) When a stop valve is located such that it allows water to accumulate, ample drains shall be provided. The drain shall be piped to a safe location and shall not be discharged on the boiler or its setting.

(C) When boilers that are provided with manholes or other similar openings that permit access for human occupancy are connected to a common steam main, the owner or operator shall ensure that the boiler to which entry is being made is completely isolated from the steam main. This may be accomplished with the use of two stop valves with an ample drain between them, with a full isolation

blind or removal of piping such that the boiler is no longer connected to the steam main.

(i) Process steam generators.

(1) Some process steam generators referred to in Section 65.10 are shown in Exhibits 5A and 5B.
Figure 1: 16 TAC §65.100(i)(1)
Figure 2: 16 TAC §65.100(i)(1)

(2) The steam collection or liberation drums of a process steam generator shall be constructed in accordance with the American Society of Mechanical Engineers (ASME) Section VIII, Division 1 or Division 2, and shall be stamped with the U or U2 symbol. As an alternate the process steam generator may be constructed to ASME Code, Section I.

(3) When the owner/operator elects to construct a process steam generator to ASME Code, Section I, the limits as shown in Exhibits 5A and 5B are as defined in the rules of ASME Section I.

(4) Safety valves and safety relief valves.

(A) The use of weighted-lever safety valves, or safety valves having either the seat or disk of cast iron is prohibited.

(B) Each ASME Code, Section VIII, Division 1 or Division 2 steam collection or liberation drum of a process steam generator shall have at least one safety valve designed for steam service with the V or UV stamp. The valve body drain shall be open and piped to a safe point of discharge.

(i) The installation of full-area stop valves between the steam collection or liberation drum of a process steam generator and the safety valve is permitted as depicted in Exhibit 5A and 5B. A full-area stop valve may be installed on the discharge of the safety valve when connected to a common header. Stop valves shall be car sealed or locked in the open position.

(ii) One or more safety valves on every steam collection or liberation drum of a process steam generator shall be set at or below the maximum allowable working pressure. The remaining valves, if any, shall be set within the range specified and have the capacity required by the applicable ASME code.

(C) Each ASME Code, Section I process steam generator shall have one safety valve and if it has more than 500 square feet (47 square meters) of water heating surface it shall have two or more safety valves. ASME Code, Section I safety valves shall be V stamped.

(i) The valve or valves shall be connected to the steam collection or liberation drum of the process steam generator, independent of any other steam connection, and attached as close as practicable to the steam collection or liberation drum without unnecessary intervening pipe or fittings.

(ii) No valves of any description shall be placed between the required safety valve or safety relief valve or valves and the steam collection or liberation drum, nor on the discharge pipe between the safety valve or safety relief valve and the atmosphere.

(iii) The safety valve capacity of each process steam generator must allow the safety valve or valves to discharge all the steam that can be generated by the process steam generator without allowing the pressure to rise more than 6.0% above the highest pressure to which any valve is set, and to no more than 6.0% above the maximum allowable working pressure.

(D) When a discharge pipe open to the atmosphere is used, it shall be at least full size of the safety valve discharge and fitted with an open drain to prevent water lodging in the upper part of the safety valve or discharge piping. The drain or drains shall be piped to a safe point of discharge. When an elbow or fitting is installed on the discharge pipe it shall be located close to the safety valve outlet. The discharge pipe shall be securely anchored and supported. All safety valve discharges shall be located or piped to a safe point of discharge clear from walkways or platforms.

(E) When two or more steam collection or liberation drums of process steam generators, operating at different pressures and safety valve settings are interconnected, the lower pressure process steam generator(s) or interconnected piping shall be equipped with safety valves of sufficient capacity to prevent overpressure, considering the maximum generating capacity of all of process steam generators.

(5) Feedwater supply.

(A) Each steam collection or liberation drum of a process steam generator shall have a feedwater supply which will permit it to be fed at any time while under pressure.

(B) Feedwater piping to a process steam generator constructed to ASME Code, Section I shall be provided with a check valve near the process steam generator and a stop valve or cock between the check valve and the process steam generator. When two or more process steam generators are fed from a common source there shall also be a stop valve on the branch to each process steam generator between the check valve and the source of supply. Whenever a globe valve is used on the feedwater piping, the inlet shall be under the disk of the valve.

(C) Where deaerating heaters are not used, it is recommended that the temperature of the feedwater be not less than 120 degrees Fahrenheit (49 degrees Celsius) to avoid the possibility of setting up localized stress. Where deaerating heaters are used, it is recommended that the minimum feedwater temperature be not less than 215 degrees Fahrenheit (102 degrees Celsius) so that dissolved gases may be thoroughly released.

(6) Water level indicators.

(A) ASME Code, Section I process steam generators with a MAWP of 400 psig (three megapascals) or less shall have at least one gage glass. For a MAWP over 400 psig (three megapascals) shall have two required gage glasses. When two gage glasses are required one of the gage glasses may be replaced by two independent remote level indicators that are maintained in simultaneous operation while the process steam generator is in service.

(B) Each steam collection or liberation drum of an ASME Code, Section VIII, Division 1 or Division 2 process steam generator, irrespective of pressure and temperature, as shown in Exhibit 5A and 5B shall be provided with one direct reading water level indicator (water gage glass) or two independent remote level indicators that are maintained in simultaneous operation while the process steam generator is in service.

(C) In all installations where direct visual observations of the water gage glass(es) cannot be made, two remote level indicators shall be provided at operational level.

(D) The gage glass cock connections shall not be less than 1/2 inch nominal pipe size (diameter nominal 15).

(E) No outlet connections, except for feedwater regulator, drains, steam gages, or apparatus of such form as does not permit the escape of an appreciable amount of steam or water therefrom, shall be placed on the pipes connecting a water column or gage glass on the steam collection or liberation drum of a process steam generator.

(F) The water column shall be fitted with a drain cock or drain valve of at least 3/4 inch nominal pipe size (diameter nominal 20). The water column blowdown pipe shall not be less than 3/4 inch nominal pipe size (diameter nominal 20) and shall be piped to a safe point of discharge.

(G) Connections from the steam collection or liberation drum of a process steam generator to remote level indicators shall be at least 3/4 inch nominal pipe size diameter nominal 20), to and including the isolation valve, and at least 1/2 inch (13 millimeters) OD tubing from the isolation valve to the remote level indicator. These connections shall be completely independent of other connections for any function other than water level indication.

(7) Low-water cutoffs, alarms and feed regulating devices.

(A) The owner/operator is responsible for the design and installation of any low water protection devices as required to prevent damage to the process steam generator. All installed low water cutoffs, alarms and feeding devices shall be designed for a pressure and temperature equal to or greater than the maximum allowable working pressure and temperature of the process steam generator steam collection or liberation drum.

(B) When a low-water cutoff, and/or alarm is housed in either the water column or a separate chamber, it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the low-water cutoff and/or alarm device.

(C) Should a steam collection or liberation drum of a process steam generator be installed in a system without a local and constant attendant, and it is not a fail safe design, it shall be provided with a low-water cutoff as required for power boilers.

(8) Pressure gages.

(A) Each steam collection or liberation drum of a process steam generator shall have a pressure-indicating device that is easily readable from the primary operating station. The range shall be graduated to approximately double the pressure at which the safety valve is set, but in no case, less than one and one-half times this pressure. The pressure-indicating device shall be connected to the steam space, or to the water column, or its steam connection. A valve or cock shall be placed in the gage connection adjacent to the gage. An additional valve or cock may be located near the steam collection or liberation drum of the process steam generator. No other shutoff valves shall be located between the gage and the steam collection or liberation drum of the process steam generator. The pipe connection shall be of ample size and arranged so that it may be cleared by blowing down or flushing. The pressure-indicating device shall be provided with a siphon or equivalent device, which will develop and maintain a water seal that will prevent steam from entering the pressure-indicating device.

(B) Each steam collection or liberation drum of a process steam generator must have a valved connection at least 1/4 inch nominal pipe size (diameter nominal 8) connected to the steam space for the purpose of attaching a test gage when the process steam generator is in service to test the accuracy of the pressure-indicating device.

(9) Stop valves.

(A) Each steam outlet from a ASME Code, Section I process steam generator shall be fitted with a stop valve located as close as practicable to the steam collection or liberation drum of the process steam generator.

(B) When a stop valve is located that allows water to accumulate, ample drains shall be provided. The drain shall be piped to a safe location and shall not be discharged on the process steam generator or its setting.

(C) When boilers that are provided with manholes or other similar openings that permit access for human occupancy are connected to a common steam main, the owner or operator shall ensure that the boiler to which entry is being made is completely isolated from the steam main. This may be accomplished with the use of two stop valves with an ample drain between them, with a full isolation blind or removal of piping such that the boiler is no longer connected to the steam main.

(j) Nuclear boilers.

(1) Nuclear boilers shall be inspected inservice by the owner or operator in accordance with ASME Boiler and Pressure Vessel Code, Section XI.

(2) The owner or operator shall engage the services of an inspection agency, qualified in accordance with American National Standards Institute/American Society of Mechanical Engineers (ANSI/ASME) N626.1, licensed by the Texas State Board of Insurance, and authorized to provide inspection services by the executive director.

(3) The chief inspector shall assign, after receipt of the completed N-3 owner's data report, a state serial number to the nuclear boiler.

(A) All N-5 data reports for piping systems and N-3 owner's data reports shall be filed with the chief inspector.

(B) National Board registration described in Section 65.50(a) or Section 65.20(c)(1)(D) is not required.

(4) The certificate of operation will be issued after receipt of the preservice inspection summary report and prior to commercial service. The summary report shall include all activities required by ASME Code, Section XI, except for the results of examinations or test of items obtainable only during power ascension testing. These items shall be filed as an amendment to the summary report within 60 days of the completion of the power ascension testing. The items identified to be submitted in the amendment shall be agreed upon by mutual consent as provided for in paragraph (11) of this subsection prior to power ascension testing and issuance of the certificate of operation.

(5) The inservice inspection plan shall be submitted to the chief inspector by the owner or operator prior to commercial service.

(6) The chief inspector shall review the inservice inspection plan and select those items necessary to verify compliance with the Health and Safety Code, Chapter 755 and ASME Code, Section XI. Items selected for verification shall be from within the verification boundary of the nuclear boiler consisting of the components and component supports of the systems illustrated in Exhibit 6.
Figure 16 TAC §65.100(j)(6)

(7) The chief inspector shall, upon reasonable notification by the owner or operator of inservice inspection activities to be accomplished during any outage on items selected in subsection (h) of this section, coordinate with the owner or operator the verification activities.

(8) The chief inspector shall review and maintain summary reports of the inservice inspections that are submitted by the owner or operator in accordance with ASME Code, Section XI.

(9) Repairs and/or replacements shall conform to the requirements of ASME Code, Section XI.

(10) The owner or operator shall, in case of serious accidents to a nuclear boiler involving a breach of the pressure boundary integrity of components included in Exhibit 6 immediately notify the chief inspector by the most expeditious means available and apprise him of the nature of the accident. The chief inspector shall assess the nature of the accident, formulate inspection activities as required, and coordinate these activities with the owner or operator and as necessary with other state and federal agencies having jurisdiction.

(11) If exceptions or situations arise which are not specifically addressed in this section or other sections of the Boiler Law and Rules, or in ASME Code, Section XI, the owner or operator shall contact the chief inspector for guidance or interpretation.

(k) Heating boilers.

(1) Steam heating.

(A) Safety valves.

(i) Each steam boiler shall have one or more officially rated safety valves of the spring pop type adjusted and sealed to discharge at a pressure not to exceed 15 psig (103 kilopascals). Seals shall be attached in a manner to prevent the valve from being taken apart without breaking the seal. The safety valves shall be arranged so that they cannot be reset to relieve at a higher pressure than the maximum allowable working pressure of the boiler. A body drain connection below seat level shall be provided. For valves exceeding 2 1/2 inch nominal pipe size (diameter nominal 65), the drain hole or holes shall be tapped not less than 3/8 inch nominal pipe size (diameter nominal 10). For valves 2 1/2 inch nominal pipe size (diameter nominal 65) or less, the drain hole shall not be less than 1/4 inch (6 millimeters) in diameter.

(ii) Each safety valve 3/4 inch nominal pipe size (diameter nominal 20) or over used on a steam boiler shall have a substantial lifting device which will positively lift the disk from its seat at least 1/16 inch (1.6 millimeters) when there is no pressure on the boiler. The seats and disks shall be of suitable material to resist corrosion.

(iii) No safety valve for a steam boiler shall be smaller than 1/2 inch nominal pipe size (diameter nominal 15). No safety valve shall be larger than 4 1/2 inches nominal pipe size (diameter nominal 115). The inlet opening shall have an inside diameter approximately equal to, or greater than, the seat diameter.

(iv) The minimum relieving capacity of valve or valves shall be governed by the capacity marking on the boiler.

(v) The minimum valve capacity in pounds per hour shall be the greater of that determined by dividing the maximum Btu output at the boiler nozzle obtained by the firing of any fuel for which the unit is installed by 1,000, or shall be determined on the basis of the pounds of steam generated per hour per square foot of boiler heating surface as given in Table 1 of Exhibit 2. For cast iron boilers, the minimum valve capacity shall be determined by the maximum output method. In every case, the safety valve capacity for each steam boiler shall be such that with the fuel burning equipment installed, and operated at maximum capacity, the pressure cannot rise more than five psig (35 kilopascals) above the maximum allowable working pressure.
Figure 16 TAC §65.100(k)(1)(A)(v)

(vi) Safety valve piping. No valve shall be placed between the safety valve and the boiler or on the discharge pipe between the safety valve and the atmosphere. When a discharge pipe is used, it shall be full size and fitted with an open drain to prevent water from lodging in the upper part of the safety valve or relief valve or in the discharge pipe. When an elbow is placed on the safety valve discharge pipe, it shall be located close to the valve outlet. The discharge pipe shall be securely anchored and supported, independent of the valve.

(B) Feedwater connections.

(i) Feedwater, or water treatment shall be introduced into a boiler through the return piping system or through an independent feedwater connection which does not discharge against parts of the boiler exposed to direct radiant heat from the fire. Feedwater, or water treatment shall not be introduced through openings or connections provided for inspection or cleaning, safety valve, surface blowoff, water column, water gage glass, pressure gage, or temperature gage.

(ii) Feedwater pipe shall be provided with a check valve near the boiler and a stop valve or cock between the check valve and the boiler or return pipe system.

(C) Low-water fuel cutoffs and water feeding devices.

(i) All automatically fired steam boilers, except boilers having a constant attendant, who has no other duties while the boiler is in operation, shall be equipped with approved automatic low-water fuel cutoffs installed in such a manner that they cannot be rendered inoperative by the manipulation of any manual control or regulating apparatus. The low-water fuel cutoff devices shall be tested regularly by lowering the water level in the boiler sufficiently to shut off the fuel supply to the burner when the water level reaches the lowest safe level for operation.

(ii) The MAWP of all low water fuel cutoff devices shall be set at or above the boiler stamped MAWP.

(iii) When low-water fuel cutoff and feedwater pump controls are combined in a single device, an additional separate low-water fuel cutoff shall be installed. The additional control shall be wired in series electrically with the existing low-water fuel cutoff.

(iv) When a low-water fuel cutoff is housed in either the water column or a separate chamber it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the low-water fuel cutoff device.

(v) If a water feed device is utilized, it shall be constructed to prevent feedwater from entering the boiler through the water column or separate chamber of the low-water fuel cutoff.

(D) Pressure gages.

(i) Each steam heating boiler shall have a pressure gage connected to the device exterior to the boiler. The gage shall be of sufficient capacity to keep the gage tube filled with water and arranged so that the gage cannot be shut off from the boiler except by a cock with tee or lever handle placed in a pipe near the gage. The handle of the cock shall be parallel to the pipe in which it is located when the cock is open.

(ii) The scale on the dial of a steam heating boiler pressure gage shall be graduated to not less than 30 psig (207kilopascals) nor more than 60 psig (414 kilopascals). The travel of the pointer from zero to 30 psig (207 kilopascals) pressure shall be at least three inches.

(E) Stop valves.

(i) Single steam heating boilers. When a stop valve is used in the supply pipe connection of a single steam heating boiler, there shall be one used in the return pipe connection.

(ii) Supply and return line. Each supply and return line to a steam heating boiler, which may be entered while adjacent

boilers are in operation, shall be fitted with either two stop valves with ample drain between or a stop valve and figure 8 blank. The blank shall be installed between the stop valve and the boiler.

(iii) Type of stop valve. When stop valves over two inches in size are used, they shall be of the outside screw-and-yoke rising stem type or of such other type as to indicate at a distance whether it is closed or open by the position of its stem or other operating mechanism. The wheel may be carried either on the yoke or attached to the stem. If the valve is of the plug cock type, it shall be fitted with a slow opening mechanism and an indicating device and the plug shall be held in place by a guard or gland.

(F) Bottom blowdown or drain valve.

(i) Bottom blowoff valve. Each steam heating boiler shall have a bottom blowoff connection fitted with a valve or cock connected to the lowest water space practicable with a minimum size as shown in Table 2 of Exhibit 2 in Figure 65.100(k)(1)(A)(v). The discharge piping shall be full size to the point of discharge. Boilers having a capacity of 25 gallons (95 liters) or less are exempt from these requirements.

(ii) Drain valve. Each boiler shall have one or more drain connections, fitted with valves or cocks connecting to the lowest water containing spaces. The minimum size of the drain piping, valves, and cocks shall be 3/4 inch nominal pipe size (diameter nominal 20). The discharge piping shall be full size to the point of discharge. When the blowoff connection is located at the lowest water containing space, a separate drain connection is not required.

(iii) Minimum pressure rating. The minimum pressure rating of valves and cocks used for blowoff or drain purposes shall be at least equal to the pressure stamped on the boiler, but in no case less than 30 psig (207 kilopascals). The temperature rating of such valves and cocks shall not be less than 250 degrees Fahrenheit (121 degrees Celsius).

(G) Water gage glasses.

(i) Each steam heating boiler shall have one or more water gage glasses attached to the water column or boiler by means of valved fittings not less than 1/2 inch nominal pipe size (diameter nominal 15). The lower fitting shall have a drain valve of the straightway type with opening not less than 1/4 inch (6 millimeters) diameter to facilitate cleaning. Gage glass replacement shall be possible under pressure.

(ii) Transparent material, other than glass, may be used for the water gage provided that the material will remain transparent and has proved suitable for the pressure, temperature, and corrosive conditions encountered in service.

(2) Hot water heating.

(A) Safety relief valves.

(i) Each hot water heating boiler shall have at least one officially rated safety relief valve set to relieve at or below the maximum allowable working pressure of the boiler.

(ii) When more than one safety relief valve is used on a hot water heating boiler, the additional valve or valves shall be officially rated and may have a set pressure within a range not to exceed six psig (42 kilopascals) above the maximum allowable working pressure of the boiler up to and including 60 psig (414 kilopascals), and 5.0% for those having a maximum allowable working pressure exceeding 60 psig (414 kilopascals).

(iii) Safety relief valves shall be spring loaded. Safety relief valves shall be set and sealed so that they cannot be reset without breaking the seal. A body drain connection below seat level shall be provided. For valves exceeding 2 1/2 inch nominal pipe size (diameter nominal 65), the drain hole or holes shall be tapped not less than 3/8 inch nominal pipe size (diameter nominal 10). For valves of 2 1/2 inch nominal pipe size (diameter nominal 65) or less, the drain hole shall not be less than 1/4 inch (6 millimeters) diameter.

(iv) Each safety relief valve shall have a substantial lifting device which will positively lift the disk from its seat at least 1/16 inch (1.6 millimeters) when there is no pressure on the boiler.

(v) Seats and disks of safety relief valves shall be made of a suitable material to resist corrosion. No materials likely to fail due to deterioration or vulcanization, when subjected to saturated steam temperature corresponding to capacity test pressure, shall be used for any part.

(vi) No safety relief valve shall be smaller than 3/4 inch nominal pipe size (diameter nominal 20) nor larger than 4 1/2 inch nominal pipe size (diameter nominal 115) except that boilers having a heat input not greater than 15,000 Btu/hr (4.4 kilowatts) may be equipped with a rated safety relief valve of 1/2 inch nominal pipe size (diameter nominal 15). The inlet opening shall have an inside diameter approximately equal to, or greater than, the seat diameter. In no case shall the minimum opening through any part of the valve be less than 1/4 inch (6 millimeters) diameter or its equivalent area.

(vii) The required steam relieving capacity, in pounds per hour, of the pressure relieving device or devices on a boiler shall be the greater of that determined by dividing the maximum output in Btu at the boiler nozzle obtained by the firing of any fuel for which the unit is installed by 1,000, or shall be determined on the basis of pounds of steam generated per hour per square foot of boiler heating surface as given in Table 1 Exhibit 2 as shown in Figure 65.100(k)(1)(A)(v). For cast iron boilers the minimum valve capacity shall be determined by the maximum output method.

(viii) In every case, the safety relief valve capacity for each boiler with a single safety relief valve shall be such that, with the fuel burning equipment installed and operated at maximum capacity, the pressure cannot rise more than 10% above the maximum allowable working pressure. When more than one safety relief valve is used, the overpressure shall be limited to 10% above the set pressure of the highest set valve.

(ix) Safety relief valve piping. No valve shall be placed between the safety relief valve and the boiler or on the discharge pipe between the safety relief valve and the drain. When a discharge pipe is used, it shall be full size and fitted with an open drain to prevent water from lodging in the upper part of the safety relief valve or in the discharge pipe. When an elbow is placed on the safety relief valve discharge pipe, it shall be located close to the valve outlet. The discharge pipe shall be securely anchored and supported, independent of the valve.

(B) Makeup water connections.

(i) Makeup water, or water treatment shall be introduced into a boiler through the return piping system or through an independent makeup water connection which does not discharge against parts of the boiler exposed to direct radiant heat from the fire. Makeup water, or water treatment shall not be introduced through openings or connections provided for inspection or cleaning, safety relief valve, pressure gage, or temperature gage.

(ii) Makeup water pipe shall be provided with a check valve near the boiler and a stop valve or cock between the check valve and the boiler or between the check valve and the piping system.

(C) Low-water fuel cutoffs and water feeding devices.

(i) All automatically fired hot water heating boiler shall have an automatic low-water fuel cutoff that has been designed for hot water service, and it shall be so located as to automatically cut off the fuel supply when the surface of the water falls to a level below the normal waterline established.

(ii) The MAWP of all low water fuel cutoff and flow sensing devices shall be set at or above the boiler stamped MAWP.

(iii) When low-water fuel cutoff and feedwater pump controls are combined in a single device, an additional separate low-water fuel cutoff shall be installed. The additional control shall be wired in series electrically with the existing low-water fuel cutoff.

(iv) When a low-water fuel cutoff is housed in either the water column or a separate chamber it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the low-water fuel cutoff device.

(v) As there is no normal water line to be maintained in a hot water heating boiler, any location of the low-water fuel cutoff above the lowest safe water level established by the boiler manufacturer is satisfactory.

(vi) All automatically fired hot water heating boilers, when installed in a forced circulation system and not under continuous attendance, shall be equipped in the manner described in this subsection. A coil-type boiler or a water-tube boiler requiring forced circulation to prevent overheating of the coils or tubes shall have a flow sensing device which is listed by a nationally recognized testing agency to prevent burner operation at a flow rate inadequate to protect the boiler unit against overheating.

(vii) If a water feed device is utilized, it shall be constructed to prevent feedwater from entering the boiler through the water column or separate chamber of the low-water fuel cutoff.

(D) Pressure gages.

(i) Each hot water heating boiler shall have a pressure or altitude gage connected to it or to its flow connection which cannot be shut off from the boiler except by a cock with tee or lever handle placed in a pipe near the gage. The handle of the cock shall be parallel to the pipe in which it is located when the cock is open.

(ii) The scale on the dial of the pressure or altitude gage shall be graduated to not less than 1 1/2 nor more than 3 1/2 times the pressure at which the safety relief valve is set. The gage shall be provided with effective stops for the indicating pointer at the zero point and at the maximum pressure point.

(iii) Piping and tubing for pressure or altitude gage connections shall be of nonferrous metal when smaller than 1 inch nominal pipe size (diameter nominal 25).

(E) Stop valves.

(i) Stop valves shall be located at an accessible point in the supply and return pipe connections near the boiler nozzle of a single hot water heating boiler installation to permit draining the boiler without emptying the system.

(ii) When the boiler is located above the system and can be drained without draining the system, stop valves may be eliminated.

(iii) Type of stop valve. When stop valves over two inches in size are used, they shall be of the outside screw-and-yoke rising stem type or of such other type as to indicate at a distance whether it is closed or open by the position of its stem or other operating mechanism. The wheel may be carried either on the yoke or attached to the stem. If the valve is of the plug cock type, it shall be fitted with a slow opening mechanism and an indicating device and the plug shall be held in place by a guard or gland.

(F) Drain valve.

(i) Each hot water heating boiler shall have one or more drain connections, fitted with valves or cocks connecting to the lowest water containing spaces. The minimum size of the drain piping, valves, and cocks shall be 3/4 inch nominal pipe size (diameter nominal 20). The discharge piping shall be full size to the point of discharge. When the blowoff connection is located at the lowest water containing space, a separate drain connection is not required.

(ii) Minimum pressure rating. The minimum pressure rating of valves and cocks used for blowoff or drain purposes shall be at least equal to the pressure stamped on the boiler, but in no case less than 30 psig (207 kilopascals). The temperature rating of such valves and cocks shall not be less than 250 degrees Fahrenheit (121 degrees Celsius).

(G) Provisions for thermal expansion.

(i) Heating systems with open expansion tank- An indoor overflow from the upper portion of the expansion tank shall be provided in addition to an open vent, the indoor overflow to be carried within the building to a suitable plumbing fixture or basement.

(ii) Closed heating system - If the system is of closed type, an airtight tank or other suitable air cushion that is consistent with the volume and capacity of the system shall be installed, and it shall be suitably designed for a hydrostatic test pressure of two and one-half times the allowable working pressure of the system. Expansion tanks for systems designed to operate above 30 psig (207 kilopascals) shall be constructed in accordance with the ASME Code, Section VIII, Division 1. Alternatively, a tank built to ASME Section X requirements may be used if the pressure and temperature ratings of the tank are equal to or greater than the pressure and temperature ratings of the system. Provision shall be made for draining the tank without emptying the system, except for pre-pressurized tanks.

(3) Hot water supply.

(A) Safety relief valves.

(i) Each hot water supply boiler shall have at least one officially rated safety relief valve set to relieve at or below the maximum allowable working pressure of the boiler.

(ii) When more than one safety relief valve is used on a hot water supply boiler, the additional valve or valves shall be officially rated and may have a set pressure within a range not to exceed six psig (42 kilopascals) above the maximum allowable working pressure of the boiler up to and including 60 psig (414 kilopascals), and 5.0% for those having a maximum allowable working pressure exceeding 60 psig (414 kilopascals).

(iii) Safety relief valves shall be spring loaded. Safety relief valves shall be set and sealed so that they cannot be reset without breaking the seal. A body drain connection below seat level shall be provided. For valves exceeding 2 1/2 inch nominal pipe size (diameter nominal 65), the drain hole or holes shall be tapped not less than 3/8 inch nominal pipe size (diameter nominal 10). For valves of 2 1/2 inch nominal pipe size (diameter nominal 65) or less, the drain hole shall not be less than 1/4 inch (6 millimeters) diameter.

(iv) Each safety relief valve shall have a substantial lifting device which will positively lift the disk from its seat at least 1/16 inch (1.6 millimeters) when there is no pressure on the boiler.

(v) Seats and disks of safety relief valves shall be made of a suitable material to resist corrosion. No materials likely to fail due to deterioration or vulcanization, when subjected to saturated steam temperature corresponding to capacity test pressure, shall be used for any part.

(vi) No safety relief valve shall be smaller than 3/4 inch nominal pipe size (diameter nominal 20) nor larger than 4 1/2 inch nominal pipe size (diameter nominal 115) except that boilers having a heat input not greater than 15,000 Btu/hr (4.4 kilowatts) may be equipped with a rated safety relief valve of 1/2 inch nominal pipe size (diameter nominal 15). The inlet opening shall have an inside diameter approximately equal to, or greater than, the seat diameter. In no case shall the minimum opening through any part of the valve be less than 1/4 inch (6 millimeters) diameter or its equivalent area.

(vii) The required steam relieving capacity, in pounds per hour, of the pressure relieving device or devices on a boiler shall be the greater of that determined by dividing the maximum output in Btu at the boiler nozzle obtained by the firing of any fuel for which the unit is installed by 1,000, or shall be determined on the basis of pounds of steam generated per hour per square foot of boiler heating surface as given in Table 1 Exhibit 2 as shown in Figure 65.100(k)(1)(A)(v). For cast iron boilers the minimum valve capacity shall be determined by the maximum output method.

(viii) In every case, the safety relief valve capacity for each boiler with a single safety relief valve shall be such that, with the fuel burning equipment installed and operated at maximum capacity, the pressure cannot rise more than 10% above the maximum allowable working pressure. When more than one safety relief valve is used, the overpressure shall be limited to 10% above the set pressure of the highest set valve.

(ix) Safety relief valve piping. No valve shall be placed between the safety relief valve and the boiler nor on the discharge pipe between the safety relief valve and the drain. When a discharge pipe is used, it shall be full size and fitted with an open drain to prevent water from lodging in the upper part of the safety relief valve or in the discharge pipe. When an elbow is placed on the safety relief valve discharge pipe, it shall be located close to the valve outlet. The discharge pipe shall be securely anchored and supported, independent of the valve.

(B) Makeup water connections.

(i) Makeup water, or water treatment shall be introduced into a boiler through the return piping system or through an independent makeup water connection which does not discharge against parts of the boiler exposed to direct radiant heat from the fire. Makeup water, or water treatment shall not be introduced through openings or connections provided for inspection or cleaning, safety relief valve, pressure gage, or temperature gage.

(ii) Makeup water pipe shall be provided with a check valve near the boiler and a stop valve or cock between the check valve and the boiler or between the check valve and the piping system.

(C) Low-water fuel cutoffs and water feeding devices.

(i) All automatically fired hot water supply boiler shall have an automatic low-water fuel cutoff that has been designed for hot water service, and it shall be so located as to automatically cut off the fuel supply when the surface of the water falls to a level below the normal waterline established.

(ii) The MAWP of all low water fuel cutoff and flow sensing devices shall be set at or above the boiler stamped MAWP.

(iii) When low-water fuel cutoff and feedwater pump controls are combined in a single device, an additional separate low-water fuel cutoff shall be installed. The additional control shall be wired in series electrically with the existing low-water fuel cutoff.

(iv) When a low-water fuel cutoff is housed in either the water column or a separate chamber it shall be provided with a blowdown pipe and valve not less than 3/4 inch nominal pipe size (diameter nominal 20). The arrangement shall be such that when the water column is blown down, the water level in it will be lowered sufficiently to activate the low-water fuel cutoff device.

(v) As there is no normal water line to be maintained in a hot water supply boiler, any location of the low-water fuel cutoff above the lowest safe water level established by the boiler manufacturer is satisfactory.

(vi) All automatically fired hot water heating boilers, when installed in a forced circulation system and not under continuous attendance, shall be equipped in the manner described in this subsection. A coil-type boiler or a water-tube boiler requiring forced circulation to prevent overheating of the coils or tubes shall have a flow sensing device which is listed by a nationally recognized testing agency to prevent burner operation at a flow rate inadequate to protect the boiler unit against overheating.

(vii) If a water feed device is utilized, it shall be constructed to prevent feedwater from entering the boiler through the water column or separate chamber of the low-water fuel cutoff.

(D) Pressure gages.

(i) Each hot water supply boiler shall have a pressure or altitude gage connected to it or to its flow connection which cannot be shut off from the boiler except by a cock with tee or lever handle placed in a pipe near the gage. The handle of the cock shall be parallel to the pipe in which it is located when the cock is open.

(ii) The scale on the dial of the pressure or altitude gage shall be graduated to not less than 1 1/2 nor more than 3 1/2 times the pressure at which the safety relief valve is set. The gage shall be provided with effective stops for the indicating pointer at the zero point and at the maximum pressure point.

(iii) Piping and tubing for pressure or altitude gage connections shall be of nonferrous metal when smaller than 1 inch nominal pipe size (diameter nominal 25).

(E) Stop valves.

(i) Stop valves shall be located at an accessible point in the supply and return pipe connections near the boiler nozzle of a single hot water supply boiler installation to permit draining the boiler without emptying the system.

(ii) When the boiler is located above the system and can be drained without draining the system, stop valves may be eliminated.

(iii) Type of stop valve. When stop valves over two inches in size are used, they shall be of the outside screw-and-yoke rising stem type or of such other type as to indicate at a distance whether it is closed or open by the position of its stem or other operating mechanism. The wheel may be carried either on the yoke or attached to the stem. If the valve is of the plug cock type, it shall be fitted with a slow opening mechanism and an indicating device and the plug shall be held in place by a guard or gland.

(F) Drain valve.

(i) Each hot water supply boiler shall have one or more drain connections, fitted with valves or cocks connecting to the lowest water containing spaces. The minimum size of the drain piping, valves, and cocks shall be 3/4 inch nominal pipe size (diameter nominal 20). The discharge piping shall be full size to the point of discharge. When the blowoff connection is located at the lowest water containing space, a separate drain connection is not required.

(ii) Minimum pressure rating. The minimum pressure rating of valves and cocks used for blowoff or drain purposes shall be at least equal to the pressure stamped on the boiler, but in no case less than 30 psig (207 kilopascals). The temperature rating of such valves and cocks shall not be less than 250 degrees Fahrenheit (121 degrees Celsius).

(G) Provisions for thermal expansion. If a system is equipped with a check valve or pressure reducing valve in the cold water inlet line, consideration should be given to the installation of an airtight expansion tank or other suitable air cushion. Otherwise, due to the thermal expansion of the water, the safety relief valve may lift periodically. If an expansion tank is provided, it shall be constructed in accordance with the ASME Code, Section VIII, Division 1 or Section X. Except for pre-pressurized tanks, which should be installed on the cold water side, provisions shall be made for draining the tank without emptying the system.

(4) Potable water heaters.

(A) Safety relief valves.

(i) Potable water heaters (tank type) shall have at least one officially rated pressure temperature safety relief valve of the automatic reseating type set to relieve at or below the maximum allowable pressure of the heater. No safety relief valve shall be smaller than 3/4 inch nominal pipe size (diameter nominal 20).

(ii) The relief valve shall have a capacity equal to or exceeding the rated burner input of the heater. The relieving capacity for electric water heaters shall be 3,500 Btu/hr (1.0 kilowatts) per kilowatt of input.

(iii) The ASME Btu rating on the valve shall be used to determine the relieving capacity.

(iv) Relief valves shall be connected directly to the heater within the top six inches of the tank.

(v) Relief valves may be installed vertically or horizontally. The center line of the horizontal connection shall be no lower than four inches from the top of the shell.

(vi) Relief valves shall not be connected to an internal pipe in the heater, or to a cold water feed line connected to the heater.

(vii) Safety relief valve piping. No valve shall be placed between the safety relief valve and the boiler nor on the discharge pipe between the safety relief valve and the drain. When a discharge pipe is used, it shall be full size and fitted with an open drain to prevent water from lodging in the upper part of the safety relief valve or in the discharge pipe. When an elbow is placed on the safety relief valve discharge pipe, it shall be located close to the valve outlet. The discharge pipe shall be securely anchored and supported, independent of the valve.

(B) Water supply.

(i) Water supply shall be introduced into a water heater through an independent water supply connection. Water shall not be introduced through openings or connections provided for cleaning, safety relief valves, drains, pressure gage or temperature gage.

(ii) If the water supply pressure to a hot water heater exceeds 75% of the set pressure of the safety relief valve, a pressure reducing valve is required.

(C) Flow sensing device.

(i) All automatically fired potable water heater, when installed in a forced circulation system and not under continuous attendance, shall be equipped in the manner described in this subsection. A coil-type boiler or a water-tube boiler requiring forced circulation to prevent overheating of the coils or tubes shall have a flow sensing device which is listed by a nationally recognized testing agency to prevent burner operation at a flow rate inadequate to protect the boiler unit against overheating.

(ii) The MAWP of all flow sensing devices shall be set at or above the boiler stamped MAWP.

(D) Temperature gages. Each hot water heater shall have a thermometer located and connected at or near the outlet that is easily readable. The thermometer shall at all times indicate the temperatures of the water in the hot water heater.

(E) Stop valves. Stop valves should be placed in the supply and discharge pipe connections of the hot water heater installation to permit draining the heater without emptying the system.

(F) Drain valves. Each hot water heater shall have a bottom drain pipe connection fitted with a valve or cock connected to the lowest water space practical. The minimum size bottom drain shall be 3/4 inch nominal pipe size (diameter nominal 20).

(G) Provisions for thermal expansion. If a system is equipped with a check valve or pressure reducing valve in the cold water inlet line, consideration should be given to the installation of an airtight expansion tank or other suitable air cushion. Otherwise, due to the thermal expansion of the water, the safety relief valve may lift periodically. If an expansion tank is provided, it shall be constructed in accordance with the ASME Code, Section VIII, Division 1 or Section X. Except for pre-pressurized tanks, which should be installed on the cold water side, provisions shall be made for draining the tank without emptying the system.

(l) Repairs and alterations. Repairs and alterations shall conform to the current edition of the National Board Inspection Code (NBIC) and addenda; and shall be acceptable to the inspector, except that repairs and alterations may be performed by the following provided the intended work is within the scope of the issued certificate of authorization:

(1) holders of the appropriate certificate(s) of authorization from the American Society of Mechanical Engineers; or

(2) holders of a certificate of authorization from the National Board of Boiler and Pressure Vessel Inspectors for use of the R repair symbol stamp; or

(3) owner/operators of boilers who have been issued a certificate of authorization by the Texas Department of Licensing and Regulation.

(A) Issuance of the certificate of authorization will be made upon submission of an application, on forms provided by the department.

(B) Review of the applicant's program and facilities initially and at subsequent three-year intervals will be done.

(i) The review will determine the applicant has a documented program to control repairs and/or alterations conforming to minimum requirements established by the department.

(ii) The review will require demonstration of the applicant's ability to perform repairs and/or alterations by implementing on representative work the requirements of the written program.

(m) Lap seam cracks. The shell or drum of a boiler in which a typical lap seam crack is discovered along a longitudinal riveted lap-type joint shall be immediately and permanently discontinued for use under pressure. A lap seam crack is the typical crack frequently found in lap seams, which extends parallel to the longitudinal joint and is located either between or adjacent to rivet holes.

(n) Hydrostatic pressure tests.

(1) When there is a question or doubt about the extent of a defect found in a boiler, the inspector may require a hydrostatic pressure test.

(2) In preparing a boiler for a hydrostatic pressure test, the boiler shall be filled with water to the stop valve and all air vented off. If the boiler to be tested is connected with other boilers that are under pressure, such connections shall be blanked off unless they have double stop valves on all connection pipes with a drain between.

(3) During a hydrostatic pressure test of a boiler, the safety valve or valves shall be removed or each valve disc shall be held to its seat by means of a testing clamp and not by screwing down the compression screw under the spring.

(4) The metal temperature for the pressure test shall not be less than 60 degrees Fahrenheit (16 degrees Celsius) unless the owner provides information on the toughness characteristics of the material for a lower test temperature, but the maximum metal temperature shall not exceed 120 degrees Fahrenheit (50 degrees Celsius) unless a higher temperature is specified and is acceptable to the inspector.

(5) When a hydrostatic pressure test is to be applied after inspection, the pressure shall be as follows.

(A) For all cases involving the question of tightness, the pressure shall be no more than the set pressure of the safety valve or valves having the lowest setting.

(B) For all cases involving the question of safety, the pressure applied shall not exceed the lesser of that which was required by the original code of construction, or the pressure equal to that which results in an applied stress no greater than 90% of the specified minimum yield stress at test temperature of the material as published by ASME Code, Section II, Part D, current edition and addenda.

(o) Authority to set and seal safety appliances. All safety and safety relief valves for ASME Sections I, IV, and VIII Division 1 boilers must be repaired, tested, set, and sealed by one of the following, provided the scope of the issued certificate of authorization covers the work to be performed:

(1) an organization holding a valid V, HV, or UV certificate of authorization, as appropriate, issued by the American Society of Mechanical Engineers (ASME); or

(2) an organization holding a valid VR certificate of authorization issued by the National Board of Boiler and Pressure Vessel Inspectors; or

(3) an organization holding a valid owner/operator certificate of authorization issued by the department. Such authorization may be granted or withheld by the executive director.

(A) If authorization is granted and proper administrative fees as provided for in Section 65.80(b) are paid, a certificate of authorization will be issued, expiring on the triennial anniversary date. The certificate shall indicate authorization to repair ASME Sections I, IV, or VIII valves, as verified by testing and as covered by the repair organization's quality control manual. The certificate will be signed by the executive director and the chief inspector.

(B) The applicant should apply to the department for renewal of authorization and reissuance of the certificate six months prior to the date of expiration.

(C) The owner/operator certificate of authorization is renewable every three years. Before issuance or renewal of the certificate of authorization, the repair organization and its facilities are subject to a review and demonstration of its quality control system by an inspector.

(D) Before the owner/operator certificate of authorization may be issued or renewed, two valves which have been repaired by the applicant must successfully complete operational verification tests as follows:

(i) visual examination to ensure the quality of material and workmanship;

(ii) verification that critical parts meet the valve manufacturer's specifications. Critical parts that are replaced must be fabricated to the valve manufacturer's specifications. Critical parts which require repair shall meet the valve manufacturer's specifications;

(iii) tightness tests and verification;

(iv) set pressure test and verification.

(E) The purpose of the tests is to ensure that the function and operation of the valves meet the requirements of the applicable section of the ASME Code to which they are manufactured. Should any of the valves fail to meet the applicable requirements, the test shall be repeated on two valves for each valve that failed. Failure of any of these valves shall cause the applicant to investigate and document the cause of failure and state what corrective action has been taken to prevent future recurrences. Retest of the original valve is acceptable. Following proper implementation of this corrective action and after satisfactory performance, permission to receive the certificate of authorization will be granted.

(F) Field repairs are defined as any repair conducted outside a fixed repair shop location. Field repairs may be conducted with the aid of mobile facilities with repair capabilities with or without testing capabilities. Field repairs may be conducted in owner/operator facilities without the use of mobile facilities. Organizations that obtain the owner/operator certificate of authorization for in-shop/plant repairs may also perform field repairs to safety and safety relief valves provided that:

(i) qualified technicians perform such repairs;

(ii) an acceptable quality control system covering field repairs is maintained;

(iii) periodic audits of the work carried out in the field are made by quality control personnel of the certificate of authorization holder to ensure that the requirements of the quality control system are met.

(G) Provided the provisions in paragraph (F)(i)-(iii) of this paragraph are met, verification testing of field repaired valves shall not be required.

(H) Organizations that perform field repairs only must demonstrate their field repair capabilities to an inspector before the certificate of authorization may be issued or renewed. Two valves must be repaired in the field and successfully complete verification tests as described in subparagraph (D) of this paragraph. A quality control manual as required in subparagraph (J) of this paragraph must be prepared describing all field repair activities.

(I) Repair of a safety and safety relief valve is considered to be the replacement, remachining, or cleaning of any part, lapping of seat and disc, or any other operation which may affect the flow passage, capacity, function, or pressure retaining integrity. Disassembly, reassembly, and/or adjustments which affect the safety or safety relief valve function are also considered a repair. The initial installation, testing, and adjustments of a new safety valve or a safety relief valve in a boiler are not considered a repair.

(J) In general, the quality control system shall describe and explain what documents and procedures the owner/operator will use to validate a valve repair. Before issuance or renewal of the owner/operator certificate of authorization, the applicant must meet all requirements, including an acceptable written quality control system. The basic elements of a written quality control system shall be those described in Exhibit 1.

(i) The written quality control system shall also include provisions for making revisions, enabling the system to be kept current as required.

(ii) A review of the applicant's quality control system will be performed by an inspector. The review will include a demonstration of the implementation of the applicant's quality control system.

(iii) Each applicant to whom a certificate of authorization is issued shall maintain thereafter a controlled copy of the accepted quality control manual with the inspector. Except for changes which do not affect the quality control program, revisions to the quality control manual shall not be implemented until such revisions are acceptable to the inspector.

(K) It is essential that owner/operator valve repair organizations ensure that personnel making repairs to safety and safety relief valves are knowledgeable and qualified. The owner/operator shall provide documented training with minimum qualification requirements for the valve repair position. Specific requirements to be included in an individual's training are as follows:

(i) working knowledge of the organization's quality control manual;

(ii) working knowledge of the applicable requirements; and

(iii) working knowledge of the technical aspects and mechanical skills for valves being repaired or tested.

(L) Performance testing of repaired valves.

(i) For shop valves, a test stand shall be used. The test stand shall be of a size and design to ensure clean, consistent, and repetitive pop action and response to blowdown adjustment, if possible. Test gages shall be connected to the test stand in such a manner as to indicate true pressure at the inlet of the valve being tested. Test gages shall be maintained and calibrated, at least every 90 days, to a minimum of one-half of 1.0% accuracy over the upper 80% of full scale range. The use of digital gages is acceptable. All calibrations shall be documented and traceable to national standards.

(ii) Valves marked for liquid service shall be set according to the applicable manufacturer's specification.

(iii) Valves marked for steam service or having special internal parts for steam should be tested with steam. However, valves for steam service may be tested with air or nitrogen for correct opening (popping), pressure setting, and, if possible, blowdown adjustment, provided the differential in popping pressure between steam and air or nitrogen, as specified in the quality control manual, are applied to the popping point.

(iv) Valves which are repaired in place shall be tested to demonstrate set pressure.

(v) For valves which are repaired in place, a device (hydraulic, pneumatic, etc.) may be used to apply an auxiliary lifting load on the spring to a valve for testing purposes and/or making adjustments. Calibrated testing equipment shall be used and detailed testing procedures followed. In such cases, the manufacturer's recommendations shall be used to establish blowdown.

(M) When a safety or safety relief valve is repaired, a metal repair tag, as described in the quality control manual, shall be attached to the valve. As a minimum, the information on the tag will include the valve identification number, set pressure, date of repair, and certificate of authorization number.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

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William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
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For further information, please call: (512) 463-7348

CHAPTER 80. LICENSED COURT INTERPRETERS

The Texas Department of Licensing and Regulation ("Department") adopts the repeal of 16 Texas Administrative Code, §80.25 and new §80.23 and §80.25, concerning continuing education requirements in the licensed court interpreters program as published in the September 16, 2005, issue of the *Texas Register* (30 TexReg 5893) without changes. The adopted rules will not be republished.

Texas Occupations Code, §51.405, requires the Texas Commission of Licensing and Regulation ("Commission") to recognize, prepare, or administer continuing education programs for license holders and a license holder must participate in the programs to the extent required by the Commission to keep the person's license. The new rule implements this statutory requirement in the licensed court interpreters program and establishes requirements specific to that program for licensees, providers, and courses. General requirements for continuing education providers and courses are contained in 16 Texas Administrative Code, Chapter 59.

The repeal of §80.25 is necessary to follow the Department's preferred rule organizational structure concerning continuing education requirements. The new §80.23 is only a renumbering of the previous §80.25. There are no other changes to this rule section.

The new §80.25 requires a licensed court interpreter to complete eight hours of continuing education in Department-approved courses to renew a license. The continuing education hours must include two hours of instruction in ethics. The continuing education hours must be completed during the term of the current license or, in the case of a late renewal, within the one-year period prior to the date of renewal. A licensee may not receive credit for attending the same course more than once. A licensee is required to retain a copy of the certificate of completion for one year after the date of completion of the course. The rule requires that, to be approved by the Department, a provider's course must cover one or more specified topics. The rule applies to providers and courses upon the effective date of the rule. The rule applies to licenses that expire on or after September 1, 2006.

The Department has determined that the continuing education requirements set forth in the new rule are the minimum requirements necessary to maintain and enhance the knowledge and skills of licensees. The specific requirements were developed with input from a focus group that included members of the licensed court interpreter industry. The members of the Licensed Court Interpreter Advisory Board were also provided with copies of the proposal.

The Department drafted and distributed the proposed repeal and new rules to persons internal and external to the agency. The proposal was published in the *Texas Register* on September 16, 2005. The comment period closed on October 17, 2005. No public comments were received regarding the proposed repeal and new rules.

16 TAC §80.23, §80.25

The new rules are adopted under Texas Occupations Code, Chapter 51, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department. In particular, the rule implements Texas Occupations Code, §51.405.

The statutory provisions affected by the adoption are those set forth in Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 57. No other statutes, articles, or codes are affected by the adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

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William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Effective date: December 8, 2005
Proposal publication date: September 16, 2005
For further information, please call: (512) 463-7348

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16 TAC §80.25

The repeal is adopted under Texas Occupations Code, Chapter 51 which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adoption are those set forth in Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 57. No other statutes, articles, or codes are affected by the adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 82. BARBERS

16 TAC §§82.1, 82.10, 82.20 - 82.23, 82.26 - 82.28, 82.31, 82.32, 82.40, 82.65, 82.70 - 82.73, 82.75 - 82.77, 82.80, 82.90, 82.100 - 82.102

The Texas Department of Licensing and Regulation ("Department") adopts new 16 Texas Administrative Code, §§82.1, 82.10, 82.20 - 82.23, 82.26 - 82.28, 82.31, 82.32, 82.40, 82.65, 82.70 - 82.73, 82.75 - 82.77, 82.80, 82.90, and 82.100 - 82.102, regarding the licensing and regulation of barbers as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6376). Sections 82.1, 82.20, 82.21, 82.23, 82.26 - 82.28, 82.31, 82.32, 82.40, 82.65, 82.70, 82.75 - 82.77, and 82.90 are adopted without changes and will not be republished. Sections 82.10(2), 82.22(b) and (c), 82.71(c)(5), 82.72(a) and (h)(14), 82.73(e) and (g)(2), 82.80, 82.100(e)(3)(C)(ii)(I), 82.101(i), and 82.102(d)(2) are adopted with changes.

These new rules are necessary to implement acts of the 79th Texas Legislature, Senate Bill 411, which transferred the functions of the Texas State Board of Barber Examiners ("Board") to the Texas Department of Licensing and Regulation effective September 1, 2005 and abolished the Board. Therefore, it is necessary to repeal the Board's rules and adopt new administrative rules regarding the regulation of barbers under the provisions of Texas Occupations Code, Chapters 1601 and 1603. The Commission in a separate rulemaking action is repealing rules at 22 Texas Administrative Code, Chapter 51.

The new rules, for the most part, incorporate the substance of the Board's rules but reorganize the provisions in a format that is consistent with other Department programs. The reorganized rules should be more easily understood by licensees and the public. The new rules also implement statutory changes made by the 79th Texas Legislature. One important change is addressing requirements for a new category of licensee, registered examination proctor. Registered examination proctors are in-

dividuals who may become registered with the Department to grade practical examinations for the Department. This change in the rules is a result of Texas Occupations Code, §1603.256 and §1603.257, added by Senate Bill 411, which authorize the Department to use registered examination proctors in administering practical examinations and authorize the Commission to adopt rules for registered examination proctors. The Department likely will need the services of registered examination proctors to help in administering practical examinations. In addition, a reference to 16 Texas Administrative Code §60.83 concerning late renewal fees for licensees in Department programs, is added to §82.80(h). Those late renewal fees will now apply to barber licensees.

Another change is that new §82.73(d) makes the student at a barber school responsible for ensuring that a student permit is on display at all times during the student's enrollment at or near the student's work station. Previously, this was a responsibility of the barber school. The rationale for this change is that it is more appropriate for the individual student to be responsible for displaying that student's own permit. The time period for a licensee to notify the Department of a change of address, in new §82.20(i), has been increased to fourteen days from ten days in the Board rules.

The Commission adopts the rules with certain changes from the rules as proposed. The Advisory Board on Barbering on November 14, 2005 recommended adoption of the rules with the changes. In §82.10(2) the word "course" has been added to the definition of "barber refresher course" for clarity. The text of §82.72(a) has been simplified, and the ten-day notice requirement has been eliminated. This change will ease the burden of compliance with the rule and make the rule conform to similar requirements in other Department programs. A technical correction has been made to §82.72(h)(14) by substituting a period for the semi-colon at the end of the paragraph. Section 82.73(e) no longer specifies that the requested information must be written on "the back of" the permit. This change was made because the permit form issued by the Department no longer places this information on the back of the form. A similar change was made to §82.73(g)(2). Section 82.80 has been changed to separate original application fees from renewal fees for greater clarity. Section 82.80 also has been changed to eliminate language concerning an incorporated $10 fee for a newsletter. Such a fee does not exist as a separate fee. In addition, references to the $10 law and rules book fee were removed from the fee provisions for student permits and endorsement/reciprocity licenses, although the text still indicates that the law and rules book is included. This is to clarify that the entire renewal fee is one fee. In addition to the above changes, non-substantive, grammatical corrections were made to §§82.22(b) and (c), 82.71(c)(5), 82.100(e)(3)(C)(ii)(I), 82.101(i), 82.102(d)(2).

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The comment period closed on November 7, 2005. Four public comments were received. Dallas Barber and Stylist College submitted three comments. The first comment requested that the rules be changed to add a curriculum to include wig specialty/hair weaving programs. The emphasis of this rulemaking is on implementing statutory changes and reorganizing the existing rule provisions, so few substantive changes are included. For this reason, the Department does not believe that it is appropriate to consider the commenter's suggested change as part of this rulemaking. However, the Department will consider the commenter's suggestions for possible future rulemaking that would address the substance of curriculum requirements. The second comment by Dallas Barber and Stylist College discussed a statutory provision concerning cosmetology schools. Texas Occupations Code, §1602.455 requires the Department to determine whether a student has paid agreed tuition before allowing the student to transfer hours to another school. The commenter appears to want such a provision in the rules for barber schools. However, the barber statute, Texas Occupations Code, Chapter 1601, does not contain a provision comparable to that in §1602.455. Therefore, such a rule in the barber program is not expressly authorized by statute. In any event, such a rule would be beyond the scope of the current rulemaking, but may be considered at a later time. The third comment by Dallas Barber and Stylist College requested a new type of license or certification, which would include an examination, for wig/weaving specialty. Such a change would require a change in statute because the barber statute currently does not include a wig/weaving specialty license or certificate. The Commission does not have the authority to adopt such a change by rule.

The fourth comment indicated that a barber with five or more years of experience should not have to take a test to get a license, whether as a late renewal or not. This comment appears to be addressed to a statutory change which eliminated the provision for a barber licensee to renew a license up to five years after the license had expired. Senate Bill 411 repealed this provision, which was contained in Texas Occupations Code, §1601.404. As a result of this statutory change, the general late renewal provisions of Texas Occupations Code, Chapter 51 now apply to barber licensees. Section 51.401 states that a person whose license has been expired for one year or more may not renew but must apply for an original license. Because this change was statutory, the Commission does not have the authority to deviate by rule from the Chapter 51 late renewal provisions. For the reasons stated, no changes to the rules have been made based on these comments.

The new rules are adopted under the provisions of Texas Occupations Code, Chapters 51, 1601 and 1603, which authorize the Commission to adopt rules necessary to implement these chapters. In particular, the rules are adopted to implement acts of the 79th Texas Legislature, Senate Bill 411.

The statutes affected by the adoption are Texas Occupations Code, Chapters 51, 1601 and 1603. No other statutes, articles, or codes are affected by the adoption.

§82.10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--Texas Occupations Code, Chapters 1601 and 1603.

(2) Barber Refresher Course--A department-approved course to renew or update the skills of a currently licensed barber, or a barber who has not practiced for a period of time, or to prepare a formerly licensed barber for the examination.

(3) Barber School--When used in this chapter includes both barber schools and barber colleges.

(4) Beard--The beard extends from below the line of demarcation and includes all facial hair regardless of texture and shall only be trimmed, shaped or cut by a licensed barber.

(5) Board--The Advisory Board on Barbering.

(6) Commission--The Texas Commission of Licensing and Regulation.

(7) Department--The Texas Department of Licensing and Regulation.

(8) Hair Relating to Haircutting--The hair extending from the scalp of the head is recognized as the hair trimmed, shaped or cut in the process of hair cutting.

(9) License--A license, permit, certificate, or registration issued under the authority of the Act.

(10) Line of Demarcation between "the hair" and "the beard"--The demarcation boundary between scalp hair ("the hair") and facial hair ("the beard") is a line drawn from the bottom of the ear.

(11) Out of Scope--

(A) The use of any blade or cutting tool for the purpose of removing any or all corns or calluses is considered a medical practice and is prohibited. The possession or storage of any blade or cutting tool for the purpose as contemplated by this rule is prima facie evidence of use.

(B) The use of any drill or similar tool designed for use by a manicurist or pedicurist is prohibited without proof of certification of training of that manicurist or pedicurist through a program approved by the department.

(C) Any chemical currently not approved for a particular use by the EPA, FDA, or any other governmental agency is prohibited.

(D) Or any other practice prohibited by the Act or these rules.

(12) Registered Examination Proctor--An individual authorized by the Department to evaluate or grade a practical examination for the department for a certificate or license issued under Texas Occupations Code, Chapter 1601.

(13) Sideburn--A sideburn may be part of a hair cut or style that is a continuation of the natural scalp hair growth, and must not extend below the bottom of the ear lobe, and must not be connected to any other bearded area on the face. Only a licensed barber shall trim, shape or cut the sideburns with any type of razor.

§82.22. Permit Requirements--Barbershops and Manicurist Specialty Shops.

(a) To be eligible for a Barbershop or Manicurist Specialty Shop Permit, an applicant must:

(1) submit the application on a department approved form;

(2) pay the fee required under §82.80; and

(3) meet other applicable requirements of the Act and this section.

(b) Barbershop Permit--To be eligible for a barbershop permit, an applicant must meet the eligibility requirements set forth in Texas Occupations Code §1601.303.

(c) Manicurist Specialty Shop Permit--To be eligible for a Manicurist Specialty Shop Permit, an applicant must meet the eligibility requirements set forth in Texas Occupations Code §1601.305.

§82.71. Responsibilities of Shop Owner and/or Shop Manager.

(a) The owner of a barbershop or manicurist specialty shop and the shop manager in whose name the shop permit is jointly issued, if different from the owner, shall both be responsible individually and jointly for ensuring that all persons who work in a shop are properly licensed at all times. Individuals who do not hold a current license and/or permit required by the department shall not be allowed to engage in barbering. Shop owners and shop managers commit an offense in violation of department rules if an individual with an expired license or permit or no license or no permit engages in barbering in a shop.

(b) Shop owners and/or shop managers shall verify that all employees and independent contractors have current licenses and permits, as applicable.

(c) The shop owner and/or shop manager shall maintain a current list of all individuals who work in a shop at the time of inspection including employees and independent contractors who engage in barbering. The list is to be made available to department inspectors upon demand. The list shall contain at least the following information:

(1) name of each individual working in the shop;

(2) the file number (license number) for each individual;

(3) the booth rental permit number for each independent contractor (booth renter) whose booth rental permit was issued on or after September 1, 2004;

(4) whether the individual is an employee or an independent contractor who engages in barbering;

(5) the type of license or permit held by the individual (e.g., barber, manicurist);

(6) the expiration date of the individual's license and/or permit; and

(7) the expiration date of the independent contractor's booth rental permit.

(d) Each barbershop may display a barber pole. This pole shall be the traditional red, white with the optional blue.

(e) In addition, barbershops shall display the words "Barber Shop" or "Barber Salon" or any phrase containing the word "Barber" on the entrance door or window of the shop in letters at least three inches high.

(f) A barbershop or specialty shop shall not prepare for sale or consumption food and drink except by vending machine, any food or drink must be disposed of in a closed container and the shop shall be separated by a solid wall and have a separate entrance if located in the same building with a restaurant or food preparation area. This rule will not apply to a licensed barbershop or specialty shop in a department store when the sale of food and drink is not immediately adjacent to the shop.

(g) No products may be sold in a barbershop or specialty shop other than products related to the practicing of barbering, including, but not limited to shampoos and treatment products, hair dyes, bleaches, wigs, toupees and hairpieces, cosmetic preparations and skin treatments, manicuring preparations, and implements, appliances, or ornaments used on the hair, skin, or nails.

(h) Permit holders are responsible for compliance with the sanitation requirements of §82.100.

§82.72. Responsibilities of Barber Schools.

(a) If a barber school changes ownership, the new owner shall notify the department of the change and apply for a new permit from the department within thirty days of the change of ownership.

(b) The department shall inspect a barber school that has changed ownership to determine that it fulfills all requirements of the department and of the Act.

(c) A new permit fee shall be required from a barber school that has changed ownership.

(d) Each barber school must inform the department in writing which hours and days the school is open and closed.

(e) A barber school must have one barber chair available for each student in attendance on the practical floor. Additional students in attendance must be assigned to the beginner's department or theory classroom.

(f) A barber school shall furnish each student within seven days of the student's enrollment his or her own copy of the law and rules book published by the department. Each student shall retain permanent ownership of the books so that he or she will have ready access to and be knowledgeable of the laws and rules that regulate barbering.

(g) The barber school must issue within seven days of enrollment each student his or her own textbook or books which shall contain all subjects referred to in Texas Occupations Code §1601.558. The department must approve each textbook or books before it may be used in the barber school curriculum.

(h) Within 30 days of enrollment, a barber school shall furnish to or ensure that each student is equipped with his or her own personal tools which must include the following:

(1) one professional electric clipper of modern design;

(2) one neck duster;

(3) one barber shears;

(4) one thinning shears;

(5) one razor equipped with disposable blades;

(6) three barber combs;

(7) one styptic powder or liquid styptic;

(8) one tool kit (carrying kit);

(9) one hair styling brush;

(10) one neck clip;

(11) one can clipper oil;

(12) two washable uniforms;

(13) one hand held hair dryer; and

(14) one T-edger or outliner.

(i) Optional equipment for the kit will be as follows:

(1) one razor strop;

(2) one razor hone; and

(3) one straight razor.

(j) No student may take instruction or accrue hours for practical work unless he or she is equipped with the tools required above.

(k) Each barber school shall have:

(1) for each student in attendance on the practical floor, enrolled in a manicurist course outlined in §82.101, one complete manicure table, one complete set of manicuring implements for plain and sculptured nails, and one textbook with complete instructions;

(2) an adequate supply of permanent wave rods;

(3) a minimum of two canvas-type wig blocks;

(4) two mannequins, one long-haired and one short-haired;

(5) a minimum of one wig, one hairpiece, and one hairwoven piece;

(6) clock;

(7) bulletin board;

(8) fire extinguisher with current inspection report; and

(9) teacher's desk in classroom.

(l) Each classroom consultant to theory instruction in a barber school shall have a valid Texas barber teacher's certificate, an academic degree or specialized training or expertise in the subject being taught if the subject pertains to material relating to barbering.

(m) A student teacher may instruct theory only if assisted by a person holding a teaching certificate.

(n) Whenever an approved barber school is without the services of at least one teacher who has a valid Texas barber teacher's certificate for all or any portion of three consecutive business days, the owner, manager, or authorized agent of the school must notify the department in writing. This notification must be on or before the seventh calendar day following the first day of the absence, and must explain the absence and its duration or expected duration. No instruction may be provided, and no student shall accrue hours for either practical work or theory for the duration of such absence.

(o) A barber school shall submit each application for enrollment which shall include the following items;

(1) The original of the application for enrollment form.

(2) Proof of a seventh-grade education or its equivalency. This shall be in the form of a transcript or photostatic copy of the diploma, equivalency certificate, or record.

(3) Two recent, identical, permanent-type photographs, size two-inch by two-inch, with applicant's signature on front. No Polaroid photographs will be accepted.

(p) Application for enrollment in a barber school must be sent to the department in complete form within ten days of actual date of enrollment.

(q) Each barber school approved by the department shall include in its instruction the curriculum approved by the department.

(r) All hours earned by a student in a barber refresher course must be reported to the department on the school's monthly progress report, and the student permit must be returned by the school owner or manager within 7 days to the department when the student has completed 300 hours.

(s) No business other than the teaching and practicing of barbering can be operated on the premises of a barber school, with the exception of vending machines or retail products directly relating to hair care.

(t) Only a permitted barber school or a licensed barber may advertise in the yellow pages of the telephone directory under "Barber."

(u) A student enrolled in a barber school must wear a clean uniform or smock during school hours.

(v) Barber schools are responsible for compliance with the sanitation requirements of §82.100.

(w) Barber schools are responsible for compliance with the reporting requirements of §82.102.

§82.73. Responsibilities of Students.

(a) Each person enrolling in an approved barber school in Texas must apply on forms approved by the department.

(b) After the department receives the completed application for enrollment the department will issue a student permit which gives the student the right to do barber service only in the school. Affixed to the student permit will be a current photograph furnished by the student to the school in accordance with §82.72. No student permit is valid unless this photograph is attached thereto.

(c) A student permit expires 12 months after the date of enrollment. If a student has not completed the 1,500 hours required by §82.101 within 12 months from the date of enrollment, upon request by the school the department will reissue the student permit for an additional 12 month period.

(d) The student is responsible for ensuring that a student permit is on display at all times during the student's enrollment at or near the students work station. No student may accrue hours for practical work or theory unless the permit is displayed in accordance with this subsection.

(e) When a student withdraws or otherwise interrupts his or her training in a barber school, for more than 60 days, after last date of attendance, the school shall send the student permit to the department within seven days after such withdraw, or interruption. The manager or owner of the barber school shall write on the permit the last day of the student's attendance and the number of credit hours accrued by the student and shall sign the student permit.

(f) If a student returns to the same barber school after interruption the school shall notify the department in writing and a student permit shall be reissued.

(g) When a barber school accepts a transfer of a student from another school the accepting school, shall on behalf of the student, submit to the department in writing the student's enrollment application and a request that the department issue a new student permit for the transferring student.

(1) Upon receipt of the accepting schools notification of transfer the department shall notify the school at which the student was formerly enrolled of such transfer.

(2) Upon receipt of the department's transfer notification the manager or owner of the barber school shall, within seven days of receipt of the department's transfer notification, send to the department the student permit with the following information written on the permit:

(A) the last day of the student's attendance;

(B) the number of credit hours accrued by the student; and

(C) the manager's or owner's signature.

(h) No reenrolled or transferred students may take instruction or accrue hours for practical work or theory unless the new student permit issued by the department is on display at or near the student's work station.

§82.80. Fees.

(a) Application Fees:

(1) Class A Registered Barber License--$90

(2) Barber Teacher Certificate--$70

(3) Barber Technician License--$90

(4) Manicurist License--$40

(5) Student Permit--$35 (includes law and rules book)

(6) Barber by Endorsement or Reciprocity from Other States--$180 (includes law and rules book)

(7) Registered Examination Proctor--$25

(8) Barbershop Permit--$60

(9) Manicurist Specialty Shop Permit--$50

(10) Booth Rental Permit--$50

(b) Renewal Fees:

(1) Class A Registered Barber License--$90

(2) Barber Teacher Certificate--$70

(3) Barber Technician License--$90

(4) Manicurist License--$40

(5) Student Permit--$35 (includes law and rules book)

(6) Barber by Endorsement or Reciprocity from Other States--$180 (includes law and rules book)

(7) Registered Examination Proctor--$25

(8) Barbershop Permit--$60

(9) Manicurist Specialty Shop Permit--$50

(10) Booth Rental Permit--$50

(c) Barber School Fees:

(1) Original Inspection (Permit)--$1,000

(2) Re-inspection--$500

(3) School (Renewal) Permit--$300

(d) Examination Fees:

(1) Student Barber--$40

(2) Student Manicurist--$40

(3) Student Teacher--$70

(4) Five-year Barber Teacher--$70

(5) Expired License Barber (Old Texan)--$75

(e) Issuance of a revised or duplicate license, certificate or permit--$25

(f) Verification of license, permit or certificate to other states--$25

(g) Law and Rules Book Fee--$10

(h) Registered Examination Proctor Department Training Course--$50

(i) Late renewals fees for licenses, certificates and permits issued under this chapter are provided under §60.83 of this title (relating to Late Renewal Fees).

§82.100. Technical Requirements--Sanitation.

(a) Shop Conditions

(1) Establishments to be lighted and ventilated. Every barbershop, manicurist specialty shop, and barber school as defined in the Act shall be properly and adequately lighted and ventilated. An adequate volume of air must be exhausted to remove contaminants from aerosol products. Fresh air must be provided to replace air exhausted.

(2) Walls, ceilings, et cetera, to be kept clean. The walls, ceilings, furniture and other fixtures, and all other exposed surfaces

in every such establishment shall be kept clean, free from dust, and maintained in a state of good repair.

(3) Floors to be kept clean. Floors of every such establishment shall be thoroughly cleaned each day. All hair dropping upon the floor shall be removed there from as soon as practicable and in such a manner as not to cause a nuisance. Floors shall be maintained in a state of good repair.

(4) Suitable equipment. Establishments shall be suitably equipped to give adequate service to patrons and shall never be used as a living, dining, or sleeping apartment.

(5) A barbershop, manicurist specialty shop, or barber school must be in a separate room from sleeping quarters and the owner or operator shall permit no person to sleep in any room used wholly or in part as such facility. There shall be no entrances from the facility opening directly into sleeping quarters.

(6) A barbershop, manicurist specialty shop, or barber school must be separated from a place where food is prepared or served by a solid wall from floor to ceiling of lath or plaster or glass or other solid material.

(b) Water Supply, Sewerage, and Toilet Facilities

(1) All barbershops, manicurist specialty shops, or barber schools shall be supplied with an adequate supply of hot and cold water under pressure. When water is not obtained from an acceptable public supply, water must meet the bacteriological, chemical, and physical requirements for drinking water systems of the Department of State Health Services. Whenever possible, the source of water supply shall be from an existing public drinking water system. Cross connections between potable water systems and other systems or equipment containing water or other substances of unknown or questionable safety are prohibited. Protection against backflow and back siphonage shall be provided by proper airgaps or approved backflow preventers where necessary.

(2) Adequate and safe sewage facilities shall be provided. Whenever possible, the facility shall be connected to a public sewerage facility. Where public sewerage is not available, adequate treatment facilities meeting the standards of the Department of State Health Services and approved by the local health authority shall be installed to dispose of sewage.

(3) Toilet facilities with flush toilets shall be suitably located in adequately and properly ventilated compartments with closing doors that lock from the inside. Toilet facilities in toilet rooms, separate for each gender, shall be provided in all places of employment in accordance with paragraph (4) of this subsection.

(4) The number of facilities to be provided for each gender shall be based on the number of employees of that gender for whom the facilities are furnished. Where only one toilet room is reasonably available and can be locked from the inside, the rule requiring separate toilet rooms for each gender can be waived. Where such single-occupancy rooms have more than one toilet facility, only one such facility in each toilet room shall be counted for the purposes of the table: Number employees--Number water closets: 1 to 15--1; 16 to 35--2; 36 to 55--3. When persons other than employees are permitted use of toilet facilities on the premise, the number of such facilities shall be appropriately increased in accordance with the table. For each three required toilet facilities, at least one lavatory shall be located either in the toilet room or adjacent thereto. Where only one or two toilet facilities are provided, at least one lavatory so located shall be provided.

(5) Washing facilities to be provided. Every such establishment shall be provided with suitable and adequate washing facilities for barbering or specialty services. Sinks or wash basins must be of nonabsorbent material and properly trapped, with not less than one sink per three chairs for barbershops and one sink per two chairs for barber schools.

(6) Drinking water facilities. Where fountain facilities designed for drinking from the stream are provided for dispensing drinking water, such facilities shall be equipped with approved type angle jet fountain heads. No common drinking cups are permitted.

(c) Use of Equipment

(1) No barber or other person affected by these rules shall use on any person a comb, hairbrush, hair duster, mug, shaving brush, razor, shears, scissors, clippers, or tweezers or any similar articles that are not thoroughly cleaned and disinfected since last used.

(2) The use of vacuum type devices for removal of loose hair is satisfactory provided that the portion of the device coming in contact with the patron is easily removed and constructed for easy cleaning and disinfection and shall be disinfected prior to use on each patron.

(d) Attendants to Wash Hands. Attendants shall wash their hands thoroughly with soap and hot water before attending any person.

(e) Cleaning and Disinfecting.

(1) A container of liquid sterilizer shall be located at each barber chair or station in a shop or school to be used to disinfect or sterilize combs, brushes, scissors or other equipment described in subsection (c)(1) of this section, which may be safely immersed in a liquid sterilizer. Equipment and tools to be placed in the liquid sterilizer shall first be cleaned by wiping, brushing or by running water over the implement to remove hair and other contaminants before being immersed in the liquid sterilizer. The liquid sterilizer shall be kept reasonably free of hair and other debris and shall be replaced in accordance with the manufacturer's instructions.

(2) A disinfectant, germicide, or bactericide used shall be approved by the Environmental Protection Agency and used according to label instructions. When not in use, or when not in a liquid sterilizer, instruments shall be placed in dry disinfectant equipment or under germicidal ultraviolet light. Metallic instruments with a cutting edge shall be disinfected after proper washing by wiping carefully with a clean cotton pad saturated with a 70% ethyl alcohol solution, or clipper blades may be disinfected with spray-type disinfectants approved by the Environmental Protection Agency.

(3) Whirlpool Footspas

(A) As used in this section, "whirlpool footspa" or "spa" is defined as any basin using circulating water.

(B) Before use upon each patron, each whirlpool footspa shall be cleaned and disinfected in the following manner:

(i) All water shall be drained and all debris shall be removed from the spa basin.

(ii) The spa basin must be cleaned with soap or detergent and water.

(iii) The spa basin must be disinfected with an EPA-registered disinfectant with demonstrated bactericidal, fungicidal, and virucidal activity which must be used according to manufacturer's instructions.

(iv) The spa basin must be wiped clean with a dry towel.

(C) At the end of each day, each whirlpool footspa shall be cleaned and disinfected in the following manner:

(i) The screen shall be removed, all debris trapped behind the screen shall be removed, and the screen and the inlet shall be washed with soap and water or detergent and water.

(ii) Before replacing the screen, one of the following procedures shall be performed:

(I) The screen shall be washed with a chlorine bleach solution of one (1) teaspoon of 5% chlorine bleach to one (1) gallon of water, or

(II) The screen shall be totally immersed in an EPA-registered disinfectant with demonstrated bactericidal, fungicidal, and virucidal activity which must be used according to the manufacturer's instructions.

(iii) The spa system shall be flushed with low sudsing soap and warm water for at least ten (10) minutes, after which the spa shall be rinsed and drained.

(D) Every other week (bi-weekly), after cleaning and disinfecting as provided in subparagraph (C) of this paragraph, each whirlpool footspa shall be cleaned and disinfected in the following manner:

(i) The spa basin shall be filled completely with water and one (1) teaspoon of 5% bleach for each one (1) gallon of water.

(ii) The spa system shall be flushed with the bleach and water solution for 5 to 10 minutes and allowed to sit for 6 to 10 hours.

(iii) The spa system shall be drained and flushed with water before use upon a patron.

(E) A record shall be made of the date and time of each cleaning and disinfecting as required by subparagraphs (B), (C), and (D) of this paragraph and indicate whether the cleaning was a daily or bi-weekly cleaning. Cleaning and disinfecting records shall be made available upon request by either a patron or a department representative.

(F) A violation of this section may result in an administrative fine and/or disciplinary action. Each footspa not in compliance with this section may result in a separate violation.

(G) A footspa found to be in violation of the cleaning or disinfecting requirements of this rule, or a footspa for which documentation is not maintained in accordance with this rule must be removed from service and not used again until it has been cleaned and disinfected in accordance with the requirements of this rule and the records have been properly updated.

(f) Towels

(1) Individual towels required. No towels or washcloths shall be used in any such establishment for more than one person without being properly laundered and sanitized by regular commercial laundering or noncommercial laundering process. The process shall include washing with a laundry detergent and rinsing at a minimum temperature of 150 degrees Fahrenheit for not less than 20 minutes. A bleach or sanitizing cycle using a rinse containing 100 ppm of available chlorine for three minutes may be used in addition to the above wash and rinse cycle. A predrying procedure for towels and washcloths will facilitate the removal of hair. Pre or post drying temperatures should not exceed 165 degrees Fahrenheit.

(2) Wet towels and washcloths must be removed from work-stands upon completion of service to each patron.

(3) Individual headrest coverage required. Before any patron attended at any such establishment is permitted to recline in a chair, the headrest of the chair shall be covered with a clean towel or clean sheet or paper not previously used for any other purposes.

(4) Dipping towels, shaving mugs, brushes, et cetera, in water containers is prohibited.

(5) Clean linens, such as face towels, steam towels, and other linens used in any such establishment shall be kept in a closed cabinet at all times.

(6) Single use towels may be used on only one person.

(g) Use of Stick Astringent Prohibited. No alums or other astringent in stick or lump form shall be used in any such establishment. (Powdered or liquid caustics are suggested.)

(h) Creams, Lotions, and Cosmetics. All creams, lotions, and other cosmetics used for patrons must be kept in clean and closed containers.

(i) Powder Boxes. Open powder boxes must not be used in a reception room and booths for patrons. Powder must be in shakers or similar receptacles.

(j) Sanitary Removal of Creams and Semisolid Substances. Creams and other semisolid substances must be dipped from the container with disinfected articles or spatula; removing such substances with the fingers is prohibited.

(k) Communicable Diseases and Infections

(1) Employees. No person who is knowingly affected with a disease in communicable form shall work or be employed in such establishment as required in Texas Occupations Code, Chapter 1601.

(2) Patrons. No person who to his/her own knowledge is affected with a known disease in communicable form shall be attended in any such establishment.

(l) Sufficient copies of the rules under this section shall be kept posted in conspicuous places in every such establishment.

(m) To the extent that these rules are in conflict with the Americans with Disabilities Act (ADA), the ADA supersedes these rules.

(n) No animals shall be allowed in a barbershop, specialty shop, or school except animals used in the aid of sensory perceptions, such as seeing eye dogs.

§82.101. Technical Requirements--Curricula.

(a) Full-time student teacher. A person enrolled in the six-month postgraduate course as a student teacher in an approved barber school shall complete a total of 26 consecutive weeks of training in such barber school. The full-time course shall consist of not less than:

(1) seven hours, 45 minutes per day for a five-day week; or

(2) six hours, 30 minutes per day for a six-day week.

(b) Part-time student teacher. A part-time student teacher at three-fourths time shall be required to attend school either:

(1) six hours per day for a five-day week for 33 weeks, plus an additional two days; or

(2) five hours per day for a six-day week for 33 weeks, plus an additional two days.

(c) Part-time student teacher requirements. On a part-time basis, a student teacher shall complete the course of 1,000 hours in not more than 18 months or shall surrender the student certificate, unless

the student produces sufficient evidence of cause to the department in the form of an affidavit.

(d) Requirement for enrollment. No person may enroll in a teacher's course in an approved barber school before receiving a certificate of registration as a Class A barber.

(e) The curriculum to prepare a student for the examination for the teacher's certificate will consist of 1,000 hours, to include:
Figure: 16 TAC §82.101(e)

(f) The curriculum to prepare a student for the examination for the class A barber certificate will consist of 1,500 hours to include the following:
Figure: 16 TAC §82.101(f)

(g) The curriculum to prepare a student for the examination for the manicurist license will consist of 600 hours, to be completed in a course of not less than 16 weeks, to include:
Figure: 16 TAC §82.101(g)

(h) The curriculum to prepare a student for the examination for the barber technician license will consists of 300 hours, to include:
Figure: 16 TAC §82.101(h)

(i) The curriculum for a barber refresher course will consist of 300 hours to include:
Figure: 16 TAC §82.101(i)

§82.102. Technical Requirements--Reporting.

(a) Each barber school must submit to the department a monthly progress report of hours accrued by each student enrolled.

(b) The report is due to the department no later than the 15th day of the month following the month covered in the report.

(c) The Progress Report Barber School Monthly Records of Student Hours must include the following:

(1) the words "Progress Report Barber School Monthly Records of Student Hours";

(2) registered teachers' names and certificate numbers;

(3) instructors' names and license numbers;

(4) name of school and address;

(5) month and year;

(6) student names in alphabetical order (10 per page);

(7) a graph comprised of:

(A) a vertical heading of days of the month (1 - 31);

(B) student certificate number;

(C) monthly hours acquired;

(D) previous hours;

(E) grand total hours; and

(F) course;

(8) student's signature;

(9) signed by instructor or school owner.

(d) The department may refuse to accept student hours for:

(1) schools' failure to staff school with qualified instructors and teachers;

(2) lack of presence of qualified instructors and teachers in the schools; and

(3) schools' failure to conduct required instruction in theory and practical training.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

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Texas Department of Licensing and Regulation
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For further information, please call: (512) 463-6208

CHAPTER 83. COSMETOLOGISTS

16 TAC §§83.1, 83.10, 83.20 - 83.26, 83.28, 83.31, 83.40, 83.65, 83.70 - 83.73, 83.75, 83.80, 83.90, 83.100 - 83.103

The Texas Department of Licensing and Regulation ("Department") adopts new 16 Texas Administrative Code, §§83.1, 83.10, 83.20 - 83.26, 83.28, 83.31, 83.40, 83.65, 83.70 - 83.73, 83.75, 83.80, 83.90, and 83.100 - 83.103, regarding the licensing and regulation of cosmetology as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6385). Sections 83.1, 83.21, 83.22, 83.23, 83.28, 83.70, 83.71, 83.73, 83.75, 83.90, 83.100, 83.101, 83.102, and 83.103 are adopted without changes and will not be republished. Sections 83.10, 83.20, 83.24, 83.25, 83.26, 83.31, 83.40, 83.65, 83.72, and 83.80 are adopted with changes.

The purpose of the new rules is to implement Senate Bill 411 ("SB 411"), 79th Legislature, Regular Session, 2005, which transferred the regulation of cosmetology from the Texas Cosmetology Commission ("TCC") to the Texas Department of Licensing and Regulation ("TDLR") effective September 1, 2005, and which amended Texas Occupations Code, Chapter 1602 and added new Chapter 1603, relating to the regulation of cosmetology. These rules also implement House Bill 3149, 79th Legislature, Regular Session, 2005, relating to inactive license status.

Compliance with Administrative Procedure Act

The proposed new rules were filed with the Texas Register on September 19, 2005, and published on October 7, 2005. TDLR also published the proposed rules via TDLR's website, a listserve notice, and an update letter to licensees. A thirty-day public comment period closed on November 7, 2005. The Advisory Board on Cosmetology held its first meeting on October 31, 2005. The Advisory Board on Cosmetology reviewed the proposed new rules, including staff's recommended changes to the rules as proposed, as well as the public comments that were received as of the date of the Advisory Board meeting. The Advisory Board recommended adoption of the proposed new rules, including staff's recommended changes.

Public comments

Six written public comments were received by the Department in response to the proposed new rules and are summarized as follows:

Four public comments were received relating to continuing education ("CE"), two from CE providers and two from individual licensees. Both individual licensees disapproved of CE requirements for license renewal. Pursuant to Texas Occupations Code §1602.354, continuing education is mandatory for all license renewals on and after September 1, 2006. In the 79th Legislature, Regular Session, 2005, an exception to CE is granted for licensees whose license is on inactive status. The Texas Cosmetology Commission, in 22 TAC §89.76, required 12 hours of CE. The Department's proposed new rule retains 12 hours of required CE for operators and reduces required CE for specialty certificate holders to 8 required hours. One CE provider comment, from Armstrong McCall, disapproved of a $5 record fee payable by CE providers for each licensee who completes a course for continuing education credit. The fee is reasonable and necessary to cover the costs of administering the cosmetology licensing program, including continuing education for cosmetology license renewals. The second CE provider comment, from Elite Continuing Education, urged that CE providers should be permitted to offer CE correspondence courses and un-timed internet courses. Correspondence courses are permitted, subject to the Department's criteria. Timed internet courses are permitted; however, un-timed internet courses are not permitted because the hours a licensee earns are not subject to verification.

One public comment from an individual stated approval that the proposed new rules do not include language from former TCC rule 22 TAC §89.35, regulating licensee clothing.

One public comment from Dallas Barber & Stylist College stated that cosmetology student tuition should be paid before a transcript is released. This requirement arises from Texas Occupations Code, §1602.455, and is present in the proposed new rules at 16 TAC §83.73(e). The comment also stated that a student who withdraws from a cosmetology school is entitled to a refund under Texas Occupations Code, Chapter 1602. This language is also present in proposed new rule 16 TAC §83.73(e).

Oral public comments were received at the Advisory Board on Cosmetology's meeting on October 31, 2005, and are summarized as follows:

Elite Continuing Education proposed that correspondence courses and internet courses be permissible formats for cosmetologists to obtain continuing education hours. Although un-timed internet courses are not permitted because the hours a licensee earns are not subject to verification, providers may be approved to offer continuing education hours in correspondence and timed internet formats, subject to the Department's criteria. The proposed rules under 16 TAC Chapter 83 do not add to, amend, or delete a continuing education provider's ability to offer cosmetology correspondence or timed internet courses.

Texas Industrial Vocational Association disapproved of the proposed record fee payable by continuing education providers for each continuing education student record that is forwarded to the Department. The fee is reasonable and necessary to cover the costs of administering the cosmetology licensing program, including continuing education for cosmetology license renewals.

An individual proposed that an "electric file certification" be created for cosmetology manicurists who utilize an electric file during manicuring. Another individual disagreed with an electric file certification for manicurists, proposing that the existing curriculum and continuing education are sufficient for consumer and practitioner safety. The proposed rules under 16 TAC Chapter 83, at this time, do not address the creation, amendment or deletion of an electric file certification program.

North Harris College proposed that the 250 hour cosmetology instructor licensing program be eliminated in favor of the 750 hour instructor program. Also, the College of the Mainland proposed that the instructor license qualifications should be 750 hours of instructor courses in addition to a minimum of 5 years of experience as a practicing cosmetologist. Conversely, an individual stated that years of experience are unrelated to teaching skills and proposed that the licensing requirement for a cosmetology instructor not include a required minimum number of years of experience. Texas Occupations Code §1602.255 provides the parameters for an operator to be eligible for an instructor license by either completing 750 hours of instruction in cosmetology courses and methods of teaching or, alternatively, by completing two years of verifiable experience as an operator and 250 hours of instruction in cosmetology courses and methods of teaching. The proposed rules under 16 TAC Chapter 83, reiterates the requirements of licensing instructors pursuant to Texas Occupations Code §1602.255.

North Harris College requested clarification for student and examinee clothing regulations, particularly relating to whether 'scrubs,' such as a medical professional's uniform, are permitted. The proposed rules under 16 TAC Chapter 83 relating to student and examinee clothing are rules transferred from the rules of the former Texas Cosmetology Commission and are proposed without change at this time.

North Harris College, Texas Industrial Vocational Association, and the Aveda Institute of San Antonio requested clarification regarding the definition of manicuring and whether the scope of manicuring includes hair removal. This issue is clarified in Staff's recommended change to §83.10(11), the definition of manicuring, to state that a manicurist may only perform those services defined in Texas Occupations Code §1602.002(10) and (11).

The Aveda Institute, San Antonio, Texas, proposed that private schools as well as public school students should be required to complete 150 hours before seeing clients. Texas Occupations Code §1602.456 requires that schools may not receive compensation for work provided by either public and private school students until the student has completed at least 10% of the required number of hours for a license. Therefore, in a 1500 operator course, both public and private school students are required to complete at least 150 hours of instruction before a school may receive compensation for the work of public or private students. The proposed rule under 16 TAC Chapter 83 relating to a student's performance of services is a rule transferred from the rules of the former Texas Cosmetology Commission and is proposed without change at this time.

The Aveda Institute requests clarification for the accounting of the yearly fees for the Private Beauty Culture School Tuition Protection Account under proposed 16 TAC §83.40(b). In accordance with Texas Occupations Code §1602.464, a fee payable by private schools for the Private Beauty Culture School Tuition Protection Account is assessed only when the account is less than $200,000. The Comptroller invests the account in the same manner as other state funds.

Staff recommends the following changes to the rules as proposed

The following items are staff changes that reflect grammatical errors, clarifications, or both to the proposed new rules.

The change to new §83.10, as proposed, is to clarify the definition of a manicurist to state, "A manicurist may perform only those services defined in Texas Occupations Code §1602.002(10) and (11)."

The change to §83.20, as proposed is to add "pay the applicable fee under §83.80" to subsections (b) and (e). This clarifies that the fee listed in §83.80, as proposed, is required.

The changes to §83.24(a), as proposed, are to correct semicolon errors; to replace the word "who's" with the word "whose" in subsection (b) to correct a grammatical error; and to clarify a license holder's use of continuing education hours to change from an inactive to an active license status by adding: "Continuing education hours used to satisfy the requirement for changing from an inactive to an active license status may not also be utilized for a future renewal of an active license."

The change to §83.25 is to change subsection (i) to clarify that a CE provider's course may be offered until the provider ceases to hold an active provider registration, not just until the provider's registration expires. Pursuant to the Department's authority, administrative sanctions and penalties may be imposed that would cause a registration to be suspended, and accordingly, that provider's course to be no longer offered.

Another change to §83.25 is to add instructors to subsection (b) and facial instructors and manicure instructors to subsection (c). Subsection (d) is changed to state more clearly that instructors are required to complete continuing education for licensure renewal. Continuing education is mandatory for all license renewals in accordance with Texas Occupations Code, §1602.354.

The change to proposed new §83.26 is to add instructors, manicure instructors, and facial instructors to clarify that instructors are required to complete continuing education to renew their license.

The change to §83.31, as proposed, is to delete subsection (a)(10) "an inactive license" as a license with a two year term. Although an inactive license holder must reapply for an inactive status every two years, it is the underlying license that has a two year term; the renewal is of the underlying license. "Inactive" or "active" merely relates to a license status.

An additional change to §83.31, as proposed, clarifies a license holder's ability to retain their underlying license, regardless of its status.

The change to §83.40, as proposed, is to clarify payments made from the Beauty Culture School Tuition Protection Account in accordance with Texas Occupations Code, §1602.463.

The change to new §83.65, as proposed, is to correct a clerical error and clarify that the number of Cosmetology Advisory Board members is five members in accordance with Texas Occupations Code, §1602.051.

The change to new §83.72, as proposed, relating to beauty culture schools, is to replace the word "salon" with the word "school" in the last sentence of subsection (f) to correct a grammatical error and clarify the applicability of that section to schools. Also, another change to §83.72, as proposed, is to add "licensed" after word "full-time" in the first sentence of subsection (c) for clarification. Additional changes to §83.72(a) are to correct semi-colon errors.

The change to §83.80, as proposed, is to state "Inactive License--No Charge. Activate License--$25." Currently, the proposed rule states "Inactive License - $25." The change to the rule as proposed does not change the fee, but moves the fee applicability from the beginning of the process, i.e., initially applying for an inactive status, to the end of the process, i.e., applying to reactivate a license.

Additional changes to §83.80, as proposed, is to change subsection (e) to state: "Reciprocity or Endorsement--$100" from the proposed language of $153. This language reflects the former TCC fee of $100 to obtain a license by reciprocity, in addition to the fee owed to obtain the license. For instance, to obtain reciprocity for an operator license, a person must pay a $100 reciprocity fee, plus a $53 license fee.

The new rules are adopted under Texas Occupations Code, Chapters 51, 1602, and 1603, which authorize the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapters 51, 1601, 1602, and 1603. No other statutes, articles, or codes are affected by the adoption.

§83.10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--Texas Occupations Code, Chapters 1602 and 1603.

(2) Beauty Culture School--A cosmetology school licensed under the Act, public or private.

(3) Board--The Advisory Board on Cosmetology.

(4) Department--The Texas Department of Licensing and Regulation.

(5) Commission--The Texas Commission of Licensing and Regulation.

(6) Cosmetology establishment--A beauty salon, specialty salon or school, public or private, licensed under the Act.

(7) Facialist--A person who holds a specialty license and who is authorized to practice the application of facial cosmetics, manipulations, eye tabbing, arches, lash and brow tints, and the temporary removal of hair by the use of depilatory, mechanical tweezers, or wax.

(8) Instructor--An individual authorized by the Department to offer instruction in any act or practice of cosmetology under Texas Occupations Code, §1602.002.

(9) Law and Rules Book--Texas Occupations Code, Chapters 1602 and 1603, and 16 Texas Administrative Code, Chapter 83.

(10) License--A Department issued permit, certificate, approval, registration, or other similar permission required by law.

(11) Manicurist--A manicurist may perform only those services defined in Occupations Code §1602.002(10) and (11).

(12) Operator--An individual authorized by the Department to perform any act or practice of cosmetology under Texas Occupations Code, §1602.002.

(13) Registered Examination Proctor--An individual authorized by the Department to evaluate or grade a practical examination for the Department for a license issued under Texas Occupations Code, Chapter 1602.

(14) Shampoo Apprentice--A person authorized to perform the practice of cosmetology as defined in §1602.002(3), relating to shampooing and conditioning a person's hair.

(15) Specialty Instructor--An individual authorized by the Department to offer instruction in an act or practice of cosmetology limited to Texas Occupations Code, §1602.002(7), (9), and/or (10). Specialty instructors may only teach the subject matter in which they are licensed.

(16) Specialty Salon--A cosmetology establishment in which only the practice of cosmetology as defined in Texas Occupations Code, §1602.002(2), (4), (7), (9), or (10) is performed. Specialty salons may only perform the act or practice of cosmetology in which the salon is licensed.

(17) Wet disinfectant soaking container--A container with a cover to prevent contamination of the disinfectant solution and of a sufficient size such that the objects to be disinfected may be completely immersed in the disinfectant solution.

§83.20. License Requirements--Individuals.

(a) To be eligible for an operator license, facialist specialty license, manicurist specialty license, hairweaving/braiding specialty certificate, wig specialty certificate, or shampoo/conditioning specialty certificate, an applicant must:

(1) pass a written and practical examination required under §83.21;

(2) submit a completed application on a Department approved form;

(3) pay the fee required under §83.80;

(4) be at least 17 years of age;

(5) have obtained a high school diploma, or the equivalent of a high school diploma, or have passed a valid examination administered by a certified testing agency that measures the persons ability to benefit from training; and

(6) have completed the following hours of cosmetology curriculum in a beauty culture school:

(A) for an operator license, one of the following:

(i) 1500 hours of instruction in a beauty culture school; or

(ii) 1000 hours of instruction in beauty culture courses and 500 hours of related high school courses prescribed by the Department in a vocational cosmetology program in a public school.

(B) for a facialist specialty license, 750 hours of instruction.

(C) for a manicurist specialty license, 600 hours of instruction.

(D) for a hairweaving/braiding specialty certificate, 300 hours of instruction completed in not less than eight weeks from date of enrollment.

(E) for a wig specialty certificate, 300 hours of instruction completed in not less than eight weeks from date of enrollment.

(F) for a shampoo/conditioning specialty certificate, 150 hours of instruction completed in not less than four weeks from date of enrollment.

(b) To be eligible for an instructor license, facial instructor specialty license or manicure instructor specialty license, an applicant must:

(1) be at least 18 years of age;

(2) have completed the 12th grade or its equivalent;

(3) pay the fee required under §83.80; and

(4) meet the following requirements:

(A) for an instructor license, hold an active operator license and have completed one of the following:

(i) 750 hours in methods of teaching the student; or

(ii) 250 hours of student-instructor training, if the student-instructor can verify two years of working experience in a licensed beauty salon.

(B) for a facial instructor specialty license, hold an active operator or facialist specialty license and have completed one of the following:

(i) 750 hours in methods of teaching the student; or

(ii) 250 hours of student-instructor training, if the student-instructor can verify two years of facial experience in a licensed beauty salon or facial specialty salon.

(C) for a manicure instructor specialty license, hold an active operator or manicurist specialty license and have completed one of the following:

(i) 750 hours of instruction in cosmetology courses and methods of teaching in a Department approved school or program, or

(ii) 250 hours of student-instructor training, if the student-instructor can verify two years of manicure experience in a licensed beauty salon or manicure specialty salon.

(c) To be eligible for a shampoo apprentice permit, an applicant must:

(1) be at least 16 years of age; and

(2) submit a completed application on a Department approved form.

(3) An applicant is not required to pay a fee for a shampoo apprentice permit.

(4) An applicant is not required to complete instruction at a cosmetology school as a prerequisite for the issuance of a shampoo apprentice permit.

(5) An applicant may not earn credit hours at a beauty culture school as a result of time spent while holding a shampoo apprentice permit.

(d) To be eligible for a student permit, an applicant must:

(1) obtain the current law and rules book;

(2) submit a completed application on a Department approved form; and

(3) pay the fee required under §83.80.

(e) To be eligible for a student-instructor registration, an applicant must:

(1) have completed the 12th grade or its equivalent;

(2) submit a completed application on a Department approved form;

(3) pay the fee required under §83.80; and

(4) have one of the following:

(A) for an instructor license, an active operator license;

(B) for an manicure instructor specialty license, an active operator or manicure specialty license; or

(C) for a facial instructor specialty license, an active operator or facialist specialty license.

(f) To eligible for a registered examination proctor registration, an applicant must:

(1) have held an active instructor license for at least two of the five years preceding the application;

(2) hold an active instructor license;

(3) obtain a certificate of completion from a Department approved training course;

(4) submit a completed application on a Department approved form; and

(5) pay the applicable fee under §83.80.

§83.24. Inactive License.

(a) To be eligible for an inactive license, an applicant must:

(1) submit a completed application on a Department approved form; and

(2) pay the fee required under §83.80.

(b) A person whose license is inactive may not practice cosmetology authorized by that license and is not required to complete continuing education required under §83.25.

(c) To change from an inactive license to an active license, an applicant must:

(1) submit a completed application on a Department approved form;

(2) pay the fee required under §83.80; and

(3) complete the continuing education that is required for the renewal of an active license during the preceding license period. Continuing education hours used to satisfy the requirement for changing from an inactive license status to an active license status may not also be utilized for a future renewal of an active license.

§83.25. License Requirements--Continuing Education.

(a) Terms used in this section have the meanings assigned by Chapter 59 of this title, unless the context indicates otherwise.

(b) To renew an operator or instructor license on or after September 1, 2006, a licensee must complete a total of 12 hours of continuing education through Department approved courses, of which 4 hours must be in Sanitation required under the Act and this chapter.

(c) To renew a manicure instructor specialty license, manicurist specialty license, facial instructor specialty license, facialist specialty license, hairweaving/braiding specialty certificate, wig specialty certificate, and shampoo/conditioning specialty certificate on or after September 1, 2006, a licensee must complete a total of 8 hours of continuing education through Department approved courses, of which 4 hours must be in Sanitation required under the Act and this chapter.

(d) If a licensee holds an instructor license, facial instructor specialty license, or manicure instructor specialty license, then, of the total hours required under subsection (b) or (c) of this section, the licensee must complete 2 hours in Methods of Teaching in accordance with §83.101.

(e) For a timely or a late renewal, a licensee must complete the required continuing education hours within the two year period immediately preceding the renewal date.

(f) A licensee may receive continuing education hours in accordance with the following:

(1) A licensee may not receive continuing education hours for attending the same course more than once.

(2) A licensee may receive continuing education hours for a course if the course provider was approved by the former Texas Cosmetology Commission and the licensee completed the course on or after September 1, 2004 and on or before October 15, 2005.

(3) Except as provided within this subsection, a licensee will receive continuing education hours for only those courses that are registered with the Department, under procedures prescribed by the Department.

(g) A licensee shall retain a copy of the certificate of completion for a course for two years after the date of completion. In conducting any inspection or investigation of the licensee, the Department may examine the licensee's records to determine compliance with this subsection.

(h) To be approved under Chapter 59 of this title, a provider's course must be dedicated to instruction in one or more of the following topics:

(1) Texas Occupations Code, Chapters 1602 and 1603;

(2) this chapter; and/or

(3) the curriculum subjects listed in §83.101.

(i) A registered course may be offered until the expiration of the course registration or until the provider ceases to hold an active provider registration, whichever occurs first.

(j) A provider shall pay to the Department a continuing education record fee of $5 for each licensee who completes a course for continuing education credit. A provider's failure to pay the record fee for course completions submitted to the Department on or after February 1, 2006 may result in disciplinary action against the provider, up to and including revocation of the provider's registration under Chapter 59 of this title.

§83.26. Licensing Requirements--Renewals.

(a) To renew an instructor license, manicure instructor specialty license, facial instructor specialty license, operator license, manicurist specialty license, facialist specialty license, hairweaving/braiding specialty certificate, wig specialty certificate, and shampoo/conditioning specialty certificate, an applicant must:

(1) complete the continuing education requirements under §83.25;

(2) submit a completed application on a Department approved form; and

(3) pay the applicable fee required under §83.80.

(b) In addition to the requirements of subsection (a) of this section, to renew an examination proctor registration, a registrant must hold an active instructor license.

(c) To renew and maintain continuous licensure, the renewal requirements under this section must be completed prior to the expiration of the license. A late renewal means the licensee will have an unlicensed period from the expiration date of the expired license to the issuance date of the renewed license. During the unlicensed period, a

person may not perform any act of cosmetology that requires a license under this chapter.

(d) Non-receipt of a license renewal notice from the Department does not exempt a person from any requirements of this chapter.

§83.31. Licenses--License Terms.

(a) The following licenses have a term of two (2) years:

(1) operator license;

(2) manicurist specialty license;

(3) facialist specialty license;

(4) hairweaving/braiding specialty certificate;

(5) wig specialty certificate;

(6) shampoo/conditioning specialty certificate;

(7) instructor license;

(8) facial instructor specialty license;

(9) manicure instructor specialty license;

(10) booth rental (independent contractor) license;

(11) beauty and specialty salon license.

(b) The following licenses have a term of one (1) year:

(1) private beauty culture school license;

(2) public secondary or postsecondary beauty culture school certificate; and

(3) examination proctor registration.

(c) A shampoo apprentice permit expires one (1) year from the date of issuance and is not renewable.

(d) A student permit and student-instructor registration are valid for the student's duration in school until the student withdraws from school or takes an examination for licensure.

§83.40. Private Beauty Culture School Tuition Protection Account.

(a) Pursuant to §1602.463 of the Act, in the event that a student from a closed school is placed in another beauty culture school, the Private Beauty Culture School Tuition Protection Account is created to pay the tuition costs and expenses incurred by a school in providing training directly related to educating the student from the closed school.

(b) In each year in which the balance of the Private Beauty Culture School Tuition Protection Account is less than $200,000 the Department will determine a fee that shall be paid by all private beauty culture schools to the account.

(c) The necessity for assessing the fee will be determined by the Department when it conducts it's annual account balance review prior to December 31st. The fee that is assessed by the Department shall be in effect for a period of 12 months.

(d) The fee shall be paid by each private beauty culture school, upon annual renewal of the license during the 12-month period and shall be paid in addition to the renewal fee. The renewal notice sent by the Department will reflect the fee due to the account.

(e) In addition to any other fees, all new schools applying for a private beauty culture school license shall pay the prescribed fee to the account before a license will be issued.

(f) In the event a student from a closed school cannot be placed or does not accept a place in another school, a refund, calculated under the closed school's refund policy, will be paid from the Private Beauty Culture School Tuition Protection Account and the total payment of a claim may not exceed $35,000.

§83.65. Advisory Board on Cosmetology.

(a) The purpose of the Advisory Board on Cosmetology is to advise the Commission and Department on adopting rules, setting fees, and enforcing and administering the Act, as applicable.

(b) The board is composed of five licensees and persons specified in the Act. Board members will serve staggered six-year terms.

(c) Expenses can be reimbursed to board members only when the legislature has specifically appropriated money for that purpose, and only to the extent of the appropriation.

(d) Expense reimbursements to board members are limited to authorized expenses incurred while traveling to and from board meetings and shall be limited to those allowed by the State of Texas Travel Allowance Guide, the Texas Department of Licensing and Regulation policies governing employee travel allowances, and the General Appropriations Act.

§83.72. Responsibilities of Beauty Culture Schools.

(a) In addition to the requirements of Texas Occupations Code, Chapter 1602, beauty culture schools and programs are responsible for compliance with the following:

(1) sanitation requirements under §83.100;

(2) curriculum requirements under §83.101; and

(3) facility and equipment requirements under §83.102.

(b) The curriculum shall be posted in a conspicuous place in the school. A current syllabus and lesson plan for each course shall be maintained by the school and be available for inspection; and

(c) Schools must have not less than one full-time licensed instructor on staff and on duty during business hours for each 25 students in attendance, including evening classes. A school may not enroll more than three student-instructors for each licensed instructor teaching in the school on a full-time basis. The student-instructor shall at all times work under the direct supervision of the full-time licensed instructor and may not service clients, but will concentrate on teaching skills. A licensed instructor must be physically present during all curriculum activities. No credit for instructional hours can be granted to a cosmetology student unless such hours are accrued under the supervision of a licensed instructor.

(d) Schools must maintain one album to display each student permit, including affixed picture, of each enrolled student. The permits should be in alphabetical order.

(e) Schools must use a time clock to track student hours and maintain a daily record of attendance with each student personally punching the time clock in accordance with the following:

(1) Attendance records will be maintained in the school and available to the Department for a period of 48 months after the student completes or terminates attendance.

(2) Within five days of a time clock failure, written documentation must be submitted to the Department on a Department approved form stating the time clock failure. If a technician is required to repair the clock, a copy of the work order indicating date(s) of repair must be submitted as part of the written documentation.

(3) Not later than the 10th day of each month, a school must display on a Department approved form the monthly hour report showing the hours acquired by each student during the preceding month in an album or binder.

(4) Each student must be given the opportunity to review, under supervision, his or her hours, and to sign or initial the report. The report shall be complete, accurate, and kept available for inspection by the student or a Department representative. One copy of the monthly hour report, signed by a school official, must be given to the Department inspector at each inspection visit.

(5) Students are prohibited from preparing hour reports or supporting documents. Student-instructors may prepare hours reports.

(6) A school must properly account for the hours granted to each student. A school shall not engage in any act directly or indirectly that grants or approves student hours that are not accrued in accordance with this chapter.

(f) With the exception of a dog for sightless or hearing impaired persons, a security dog during closed hours, and aquariums containing fish, no animal, fowl, reptile, insect, etc. may be present at a beauty school.

(g) Private schools can utilize locations away from the building for instruction in the approved cosmetology school curriculum. The instruction at these locations must be identified as a field trip.

(h) All areas of a school or campus are acceptable as instructional areas for a public cosmetology school, provided that the instructor is teaching cosmetology curriculum required under §83.101.

(i) A private cosmetology school may provide cosmetology instruction to public high school students by contracting with the Texas Education Agency and complying with Texas Education Agency law and rules. A public high school student receiving instruction at a private cosmetology school in accordance with a contract between the private cosmetology school and the Texas Education Agency is considered to be a public high school student enrolled in a public school cosmetology program for purposes of the Act and Department rules.

(j) Public school students must complete 150 hours of cosmetology training prior to working on clients. No school may offer compensation to any student in any form for cosmetology services performed.

(k) Schools may enroll applicants for a refresher course. A person who holds a valid Texas license may service clients in the school. The school may receive compensation for services performed by a student holding a valid Texas license; however, the student may not receive compensation.

(l) The school principal or program administrator must certify that each public high school student has successfully completed 1,000 clocked cosmetology hours before 500 academic hours can be granted by the Department for successfully passing academically approved courses to include math, lab science and English.

(m) When a student graduates, the school must certify that the student has completed the required curriculum and that all practical applications have been completed.

§83.80. Fees.

(a) Application and renewal fees.

(1) Operator License--$53

(2) Facialist Specialty License--$53

(3) Manicurist Specialty License--$53

(4) Hairweaving/braiding Specialty Certificate--$53

(5) Wig Specialty Certificate--$53

(6) Shampoo-Conditioning Specialty Certificate--$53

(7) Student Permit--$25

(8) Instructor License--$70

(9) Facial Instructor Specialty License--$70

(10) Manicure Instructor Specialty License--$70

(11) Student-Instructor Registration--$70

(12) Examination Proctor Registration--$25

(b) Beauty Salons and Booth Rental (Independent Contractor) application and renewal fees.

(1) Original application--$106

(2) Renewal application--$69

(3) Booth Rental (Independent Contractor) License--$67

(c) Private Beauty Culture School License application and renewal fees.

(1) Original application--$500

(2) Renewal application--$200

(d) Examination fee for retake--$25

(e) License by Reciprocity or Endorsement--$100

(f) Inactive License--No charge. Activate License--$25

(g) Provisional License--$45

(h) Revised/Duplicate License/Certificate/Permit/Registration--$53

(i) Law and Rules book--$14

(j) Inspection Fees (for each occurrence).

(1) Salon--$35

(2) School (public and private)--$200

(k) Transcript Fee.

(1) Licensee transcript--$15

(2) Student transcript--$5

(l) Registered Examination Proctor Department training course--$50

(m) Late renewals fees for licenses under this chapter are provided under §60.83 of this title (relating to Late Renewal Fees).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505360
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-7348

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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 129. STUDENT ATTENDANCE SUBCHAPTER AA. COMMISSIONER'S RULES

19 TAC §129.1025

The Texas Education Agency (TEA) adopts an amendment to §129.1025, concerning student attendance accounting. The amendment is adopted without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6161) and will not be republished. The amendment adopts by reference the *2004-2005 Student Attendance Accounting Handbook* and the *2005-2006 Student Attendance Accounting Handbook*. The handbooks provide student attendance accounting rules for school districts and charter schools. Texas Education Code (TEC), §42.004, requires the commissioner, in accordance with rules of the State Board of Education (SBOE), to take such action and require such reports as may be necessary to implement and administer the Foundation School Program (FSP). SBOE rule, 19 Texas Administrative Code §129.21, delineates responsibilities of the commissioner to provide guidelines for attendance accounting, necessary records and procedures required of school districts in preparation of a daily attendance register, and provisions for special circumstances regarding attendance accounting.

Legal counsel with the TEA has recommended that the procedures contained in each annual student attendance accounting handbook be adopted as part of the *Texas Administrative Code*. This decision was made in 2000 given a court decision challenging state agency decision-making via administrative letter/publications. Given the statewide application of the attendance accounting rules and the existence of sufficient statutory authority for the commissioner of education to adopt by reference the student attendance accounting handbook, staff proceeded with formal adoption of rules in this area. The intention is to annually update the rule to refer to the most recently published student attendance accounting handbook.

Each annual student attendance accounting handbook provides school districts and charter schools with the FSP eligibility requirements of all students, prescribes the minimum requirements of all student attendance accounting systems, lists the documentation requirements for attendance audit purposes, specifies the minimum standards for systems that are entirely functional without the use of paper, and details the responsibilities of all district personnel involved in student attendance accounting. The TEA distributes FSP resources under the procedures specified in each current student attendance accounting handbook. The final version of the student attendance accounting handbook is published on the TEA web site each June/July. A supplement, if necessary, is also published on the TEA web site.

The amendment to 19 TAC §129.1025 adopts by reference the student attendance accounting handbook for the 2004-2005 school year as well as the updated version for the 2005-2006 school year. Data from previous school years will continue to be subject to the student attendance accounting handbook as the handbook existed in those years.

Significant changes to the *2004-2005 Student Attendance Accounting Handbook* include information relating to the following: (1) provisional admittance for students not fully immunized; (2) attendance rules for prekindergarten (PK) or kindergarten children; (3) funding eligibility for high school students taking college courses; (4) general requirements for early dismissal, attendance, and class schedule waivers; (5) enrollment and withdrawal procedures for blind and visually impaired students; (6) enrollment and withdrawal procedures for students served by the Texas School for the Deaf; (7) agreements between the home district and the receiving district regarding the reporting of Public Education Information Management System (PEIMS) and attendance data for special education students; (8) PEIMS coding requirements for career and technology education courses; (9) calculating contact hours for students on paid and unpaid work-based experiences and paid employment; (10) eligibility of dual credit college and secondary career and technology education courses to be counted for career and technology contact hour funding; (11) rules for conducting home language surveys of Bilingual/English as a Second Language (ESL) students; (12) qualifications for PK students who are educationally disadvantaged, if the student qualifies for free/reduced lunch or does not understand English; (13) coding requirements for Pregnancy Related Services (PRS) support services; and (14) certification requirements for teachers who teach off-campus disciplinary alternative education programs.

Changes to the *2005-2006 Student Attendance Accounting Handbook* include: (1) adding new provisions for establishing residency; (2) changing the time for sending students records; and (3) updating language and clarifying policies for General Education Homebound (GEH), PRS, Bilingual/ESL, PK limited English proficient (LEP) students, and career and technology contact hours, course completion, and enrollment.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Education Code (TEC), §42.004, which authorizes the commissioner of education, in accordance with rules of the State Board of Education, to take such action and require such reports consistent with TEC, Chapter 42, as may be necessary to implement and administer the Foundation School Program.

The amendment implements the Texas Education Code, §42.004.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505303
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 6, 2005
Proposal publication date: September 30, 2005
For further information, please call: (512) 475-1497

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TITLE 22. EXAMINING BOARDS

PART 2. TEXAS STATE BOARD OF BARBER EXAMINERS

CHAPTER 51. PRACTICE AND PROCEDURE

The Texas Department of Licensing and Regulation ("Department") adopts the repeal of 22 Texas Administrative Code, Chapter 51, Subchapter A, §§51.1 - 51.7; Subchapter B, §§51.11 - 51.21, 51.23 - 51.26, 51.28 - 51.31, 51.34, 51.35, and 51.38 - 51.40; Subchapter C, §§51.52, 51.54, 51.57 - 51.64, 51.80, and 51.83 - 51.85; Subchapter D, §§51.91 - 51.98; Subchapter E, §51.101; Subchapter F, §51.111; Subchapter H, §51.131; and Subchapter I, §51.141, concerning the Texas State Board of Barber Examiners as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6400), without changes, and it will not be republished.

The repeal is necessary to implement acts of the 79th Texas Legislature, Senate Bill 411, which transferred the functions of the Texas State Board of Barber Examiners ("Board") to the Texas Department of Licensing and Regulation effective September 1, 2005 and abolished the Board. Therefore, it is necessary to repeal the Board's rules and adopt new administrative rules regarding the regulation of barbers under the provisions of Texas Occupations Code, Chapters 1601 and 1603. The Commission in a separate, concurrent rulemaking action adopted rules at 16 Texas Administrative Code, Chapter 82, to replace the repealed rules.

The Department drafted and distributed the proposal to persons internal and external to the agency. No public comments were received specifically in response to the proposed repeal of the rules.

SUBCHAPTER A. THE BOARD

22 TAC §§51.1 - 51.7

These rules are repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505365
William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-6208

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SUBCHAPTER B. BARBER COLLEGES, SCHOOLS, AND STUDENTS

22 TAC §§51.11 - 51.21, 51.23 - 51.26, 51.28 - 51.31, 51.34, 51.35, 51.38 - 51.40

These rules are repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
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Proposal publication date: October 7, 2005
For further information, please call: (512) 463-6208

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SUBCHAPTER C. EXAMINATION AND LICENSING

22 TAC §§51.52, 51.54, 51.57 - 51.64, 51.80, 51.83 - 51.85

These rules are repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
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Texas State Board of Barber Examiners
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For further information, please call: (512) 463-6208

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SUBCHAPTER D. BARBER SHOPS

22 TAC §§51.91 - 51.98

These rules are repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules

as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
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Texas State Board of Barber Examiners
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For further information, please call: (512) 463-6208

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SUBCHAPTER E. ADVERTISING

22 TAC §51.101

The rule is repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
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For further information, please call: (512) 463-6208

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SUBCHAPTER F. CONTESTED CASES

22 TAC §51.111

The rule is repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
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For further information, please call: (512) 463-6208

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SUBCHAPTER H. INFORMAL HEARING DISPOSITION

22 TAC §51.131

The rule is repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
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For further information, please call: (512) 463-6208

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SUBCHAPTER I. DEFINITIONS

22 TAC §51.141

The rule is repealed under Senate Bill 411 Acts of the 79th Texas Legislature and Texas Occupations Code, Chapters 51, 1601, and 1603, which authorize the Department to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutes affected by the repeal are Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200505372
William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas State Board of Barber Examiners
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Proposal publication date: October 7, 2005
For further information, please call: (512) 463-6208

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PART 3. TEXAS BOARD OF CHIROPRACTIC EXAMINERS

CHAPTER 73. LICENSES AND RENEWALS

22 TAC §73.2

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §73.2, relating to Renewal of License, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6162) and will not be republished.

The rule is amended to change the expired license fee as mandated by House Bill 972, 79th Legislature. All changes are reflected in the fee schedule in §75.7 of this title (relating to Required Fees and Changes). Elsewhere in this issue of the *Texas Register*, the Texas Board of Chiropractic Examiners contemporaneously adopts an amendment to §75.7.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Occupation Code §201.152, relating to rules, and §201.153, relating to fees. Section 201.152 authorizes the Board to adopt rules necessary to regulate the practice of chiropractic. Section 201.153 authorizes the Board to set fees by rule in amounts reasonable and necessary to cover the costs of administering the Chiropractic Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505378
Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
Effective date: December 11, 2005
Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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22 TAC §73.3

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §73.3, relating to continuing education, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6164) and will not be republished.

The amendment clarifies the use of online courses and end the use of video courses. Additional editorial changes and corrections were made, where necessary.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Occupations Code, §201.152, relating to rules, and §201.356, relating to continuing education. Section 201.152 authorizes the board to adopt rules necessary to regulate the practice of chiropractic. Section 201.356 authorizes the board to adopt requirements for mandatory continuing education for license holders in subjects relating to the practice of chiropractic.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505379
Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
Effective date: December 11, 2005
Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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22 TAC §73.7

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §73.7, relating to approved continuing education courses, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6165) and will not be republished.

The amendment requires that the course title used on a sponsor's application be used to advertise a course.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Occupations Code, §201.152, relating to rules, and §201.155, relating to rules restricting advertising or competitive bidding. Section 201.152 authorizes the Board to adopt rules necessary to regulate the practice of chiropractic. Section 201.155 authorizes the Board to adopt rules to prohibit false and misleading or deceptive advertising practices.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
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Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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CHAPTER 75. RULES OF PRACTICE

22 TAC §75.7

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §75.7, relating to Required Fees and Charges, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6167) and will not be republished.

The amendment is necessary to change license late fee penalties as mandated by House Bill 972, 79th Legislature. All changes will be reflected in the fee schedule. Elsewhere in this issue of the *Texas Register*, the Texas Board of Chiropractic Examiners contemporaneously adopts an amendment to §73.2, concerning Renewal of License.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Occupation Code §201.152, relating to rules, and §201.153, relating to fees. Section 201.152 authorizes the Board to adopt rules necessary to regulate the practice of chiropractic. Section 201.153 authorizes the Board to set fees by rule in amounts reasonable and necessary to cover the costs of administering the Chiropractic Act.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
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Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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22 TAC §75.9

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §75.9, relating to complaint procedures, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6168) and will not be republished.

The amendment is required by House Bill 972, the Board's Sunset legislation, and as necessary to clarify the rule and for temporary suspensions.

Section 11 of House Bill 972, 79th Legislature, Regular Session, amended the Chiropractic Act, Texas Occupations Code §201.205(a), to require that the Board prioritize complaints for purpose of determining the order in which they are investigated, taking into account the seriousness of the allegations, and the length of time that a complaint has been pending. The Board's Enforcement Committee has prioritized its review of pending complaints for some time. This rule change will not alter the Board's practice in the exercise of its enforcement discretion. The Board will, however, publish its schedule of enforcement priorities on its web site (www.tbce.state.tx.us).

The Board's complaint form has also been revised to include a space for identifying any person that assists in filling out the form.

The Board's rule regarding temporary suspensions under §75.9(g) is revised to clarify the standards and procedures. The rule confirms that, at least, a preponderance of the evidence must support a temporary suspension.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Occupations Code, §201.152, relating to rules, and §201.507, relating to temporary license suspension. Section 201.507 authorizes the Board's Enforcement Committee to temporarily suspend a license when the continued practice of chiropractic by a licensed holder constitutes a continuing or imminent threat to the public welfare.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

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Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
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Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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CHAPTER 79. LICENSURE OF CERTAIN OUT-OF-STATE APPLICANTS

22 TAC §79.1

The Texas Board of Chiropractic Examiners (Board) adopts an amendment to §79.1, relating to general requirements for licensure of certain out-of-state applicants, without changes to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6170) and will not be republished.

The amendment is required by House Bill 972, the Board's Sunset legislation.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Occupations Code, §201.152, relating to rules, and §201.309, relating to license issuance to certain out-of-state applicants. Section 201.152 authorizes the Board to adopt rules necessary to regulate the practice of chiropractic. Section 201.309 authorizes the board to issue a license to certain out-of-state applicants under certain circumstances.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2005.

TRD-200505383
Sandra Smith
Executive Director
Texas Board of Chiropractic Examiners
Effective date: December 11, 2005
Proposal publication date: September 30, 2005
For further information, please call: (512) 305-6709

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PART 4. TEXAS COSMETOLOGY COMMISSION

CHAPTER 83. SANITARY RULINGS

22 TAC §§83.1 - 83.6, 83.9 - 83.11, 83.13, 83.14, 83.17, 83.22 - 83.30

The Texas Department of Licensing and Regulation ("Department") adopts the repeal of 22 Texas Administrative Code, Chapter 83, §§83.1 - 83.6, 83.9 - 83.11, 83.13, 83.14, 83.17, and 83.22 - 83.30, concerning the Texas Cosmetology Commission sanitary rulings as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6403) without changes.

Acts of the 79th Texas Legislature, Senate Bill 411 transferred the functions of the Texas Cosmetology Commission ("TCC") to the Texas Department of Licensing and Regulation ("Department") effective September 1, 2005 and abolished the TCC. Therefore, the Department adopts the repeal of the Texas Cosmetology Commission's existing administrative rules regarding sanitary rulings. In a separate, but concurrent rulemaking action, the Department adopts new 16 Texas Administrative Code, Chapter 83, which replaces the rules affected by the repeal.

The Department drafted and distributed the proposed repeal to persons internal and external to the agency. The proposal was published in the *Texas Register* on October 7, 2005. The comment period closed on November 7, 2005. No public comments were received regarding the proposed repeal. The Advisory Board on Cosmetology met on October 31, 2005, and agreed with the Department's rulemaking decision to repeal Chapter 83 of the TCC's administrative rules, which provides for the transfer of the sanitation rules of the TCC to the Department.

The repeal is adopted under Texas Occupations Code, Chapters 51, 1602, and 1603, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the repeal are those set forth in Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected by the repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505361
William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas Cosmetology Commission
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-7348

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CHAPTER 85. PUBLIC RECORDS

22 TAC §85.1

The Texas Department of Licensing and Regulation ("Department") adopts the repeal of 22 Texas Administrative Code, Chapter 85, §85.1, concerning the Texas Cosmetology Commission public records as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6403) without changes.

Acts of the 79th Texas Legislature, Senate Bill 411 transferred the functions of the Texas Cosmetology Commission ("TCC") to the Texas Department of Licensing and Regulation ("Department") effective September 1, 2005 and abolished the TCC. Therefore, the Department adopts the repeal of the Texas Cosmetology Commission's existing administrative rule regarding public records. This rule is no longer necessary because 16 Texas Administrative Code, Chapter 60, §60.81 of the Department rules addresses provisions for requesting copies of public records.

The Department drafted and distributed the proposed repeal to persons internal and external to the agency. The proposal was published in the *Texas Register* on October 7, 2005. The comment period closed on November 7, 2005. No public comments were received regarding the proposed repeal. The Advisory Board on Cosmetology met on October 31, 2005 and agreed with the Department's rulemaking decision to repeal Chapter 85 of the TCC's administrative rules regarding provisions for requesting copies of public records since the Department's rule §60.81 addresses these provisions.

The repeal is adopted under Texas Occupations Code, Chapters 51, 1602, and 1603, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the repeal are those set forth in Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected by the repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505362

William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas Cosmetology Commission
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
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CHAPTER 89. GENERAL RULES AND REGULATIONS

22 TAC §§89.1, 89.2, 89.4 - 89.11, 89.13 - 89.20, 89.22 - 89.24, 89.26, 89.28 - 89.36, 89.38 - 89.44, 89.46, 89.47, 89.49 - 89.57, 89.69, 89.71, 89.72, 89.74 - 89.76

The Texas Department of Licensing and Regulation ("Department") adopts the repeal of 22 Texas Administrative Code, Chapter 89, §§89.1, 89.2, 89.4 - 89.11, 89.13 - 89.20, 89.22 - 89.24, 89.26, 89.28 - 89.36, 89.38 - 89.44, 89.46, 89.47, 89.49 - 89.57, 89.69, 89.71, 89.72, and 89.74 - 89.76, concerning the Texas Cosmetology Commission's general rules and regulations as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6404), without changes.

Acts of the 79th Texas Legislature, Senate Bill 411 transferred the functions of the Texas Cosmetology Commission ("TCC") to the Texas Department of Licensing and Regulation ("Department") effective September 1, 2005 and abolished the TCC. Therefore, the Department proposes to adopt the repeal of the Texas Cosmetology Commission's existing general rules and regulations. In a separate, but concurrent rulemaking action, the Department adopts new 16 Texas Administrative Code, Chapter 83 that replaces the rules affected by the repeal.

The Department drafted and distributed the proposed repeal to persons internal and external to the agency. The proposal was published in the *Texas Register* on October 7, 2005. The comment period closed on November 7, 2005. No public comments were received regarding the proposed repeal. The Advisory Board on Cosmetology met on October 31, 2005 and agreed with the Department's rulemaking decision to repeal Chapter 89 of the TCC's administrative rules, which provides for the transfer of the rules of the TCC to the Department.

The repeal is adopted under Texas Occupations Code, Chapters 51, 1602, and 1603, which authorizes the Department to adopt rules as necessary to implement this chapter and any other law establishing a program regulated by the Department.

The statutory provisions affected by the repeal are those set forth in Texas Occupations Code, Chapters 51, 1601, and 1603. No other statutes, articles, or codes are affected by the repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505363
William H. Kuntz, Jr.
Executive Director, Texas Department of Licensing and Regulation
Texas Cosmetology Commission
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 463-7348

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PART 10. TEXAS FUNERAL SERVICE COMMISSION

CHAPTER 203. LICENSING AND ENFORCEMENT--SPECIFIC SUBSTANTIVE RULES

22 TAC §203.6

The Texas Funeral Service Commission (Commission) adopts amendments to Title 22, Part 10, Chapter 203, §203.6, concerning Provisional Licensees. The amendments are adopted without changes to the proposed text as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5239).

The adopted amendments implement changes because existing subsection (c) contains language relating to the oral exit interview and is no longer needed after the approval of the commission at the May, 2004 meeting to discontinue the oral exit interviews. Clarification of a cancelled license is also needed. Clarification is also needed in existing subsections (k) and (l) relating to the examination requirements for licensure.

No comments were received regarding the amendments.

The amendments are adopted under Texas Occupations Code, §651.152. The commission interprets §651.152 as authorizing it to adopt rules as necessary to administer Chapter 651.

No other statutes, articles, or codes are affected by the adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505353
O.C. Robbins
Executive Director
Texas Funeral Service Commission
Effective date: December 8, 2005
Proposal publication date: September 2, 2005
For further information, please call: (512) 936-2466

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22 TAC §203.27

The Texas Funeral Service Commission (Commission) adopts an amendment to 22 TAC §203.27, concerning Sponsors of Provisional Licensees. The amendment is adopted without changes to the proposed text as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5240) and will not be republished.

The amendment is adopted because existing subsection (e) contains language relating to the oral exit interview and is no longer needed after the approval of the commission at the May, 2004 meeting to discontinue the oral exit interviews.

No comments were received.

The amendment is adopted under Texas Occupations Code §651.152. The commission interprets §651.152 as authorizing it to adopt rules as necessary to administer Chapter 651.

The amendment is adopted under Texas Occupations Code, §651.152. The commission interprets §651.152 as authorizing it to adopt rules as necessary to administer Chapter 651.

No other statutes, articles, or codes are affected by the adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505331
O.C. Robbins
Executive Director
Texas Funeral Service Commission
Effective date: December 8, 2005
Proposal publication date: September 2, 2005
For further information, please call: (512) 936-2466

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22 TAC §203.29

The Texas Funeral Service Commission (Commission) adopts an amendment to 22 TAC §203.29, concerning Funeral Establishment Names, without changes to the proposed text as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5241) and will not be republished.

The amendment is adopted in order to eliminate the burden on the affected funeral establishment to object to the application. The Texas Business Corporation Act, Limited Liability Act, and Limited Partnership Act provide that the Secretary of State will not approve a name that is deceptively or substantially similar to the name of another entity, unless that entity agrees in writing to the name's use. The Commission believes this procedure should apply to funeral establishment names, as well.

The commission received no comments.

The amendment is adopted under the authority of the Texas Occupations Code, §651.152 which authorizes the commission to issue such rules and regulations as may be necessary to administer Chapter 651.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505330
O.C. Robbins
Executive Director
Texas Funeral Service Commission
Effective date: December 8, 2005
Proposal publication date: September 2, 2005
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PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 273. GENERAL RULES

22 TAC §273.4, §273.7

The Texas Optometry Board adopts amendments to §273.4 and §273.7 without changes to the proposed text published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5530).

The amendments to §273.4 raise the license renewal fees by $7.00 to provide funding for appropriations of the 79th Legislature, change the late renewal fee to 150 percent and 200 percent of the renewal amount depending on when renewal is received to correspond with amendments contained in House Bill 1025, set fees for a new category of license created by House Bill 2680 and requires each new license applicant to submit a $39.00 fee to be submitted by the Board to the Texas Department of Public Safety to obtain a criminal history record.

The amendments to §273.7 implement House Bill 2680, 79th Legislature, Regular Session, by creating a retired license with reduced renewal fees and continuing education requirements for licensees providing health care services without compensation or expectation of compensation as a direct service volunteer of a charitable organization.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Optometry Act, Texas Occupations Code, §§351.151, 351.152, 351.301, 351.308, Government Code §411.122, and House Bills 2680 and 1025, 79th Legislature, Regular Session. No other sections are affected by the amendments.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession; §351.152 as granting the Board the authority to establish by rule reasonable and necessary fees to cover the costs of administering the act; §351.301 as setting the requirements for license renewal, §351.308 as setting the requirements for continuing education, §411.122 authorizes the agency to obtain criminal history records. House Bill 1025 changes the computation of the late renewal fee; and House Bill 2680, requiring a retired license with reduced renewal fees and continuing education requirements for licensees providing health care services without compensation or expectation of compensation as a direct service volunteer of a charitable organization.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505289

Chris Kloeris
Executive Director
Texas Optometry Board
Effective date: December 6, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 305-8502

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CHAPTER 275. CONTINUING EDUCATION

22 TAC §275.1

The Texas Optometry Board adopts amendments to §275.1 without changes to the proposed text published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5531).

The amendments implement House Bill 2680, 79th Legislature, Regular Session, by setting reduced continuing education requirements for licensees providing health care services without compensation or expectation of compensation as a direct service volunteer of a charitable organization.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Optometry Act, Texas Occupations Code, §351.151, §351.308 and House Bill 2680, 79th Legislature, Regular Session. No other sections are affected by the amendments.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession, §351.308 as setting the requirements for annual continuing education courses, and House Bill 2680, requiring a retired license with reduced renewal fees and continuing education requirements for licensees providing health care services without compensation or expectation of compensation as a direct service volunteer of a charitable organization.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505290
Chris Kloeris
Executive Director
Texas Optometry Board
Effective date: December 6, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 305-8502

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CHAPTER 277. PRACTICE AND PROCEDURE

22 TAC §277.1, §277.9

The Texas Optometry Board adopts amendments to §277.1 and new §277.9. Section 277.1 is adopted with changes to the proposed text published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5532). Section 277.9 is adopted without changes and will not be republished.

The amendments to §277.1 classify complaints, require that two board members investigate complaints that directly relate to patient care, authorize the agency to issue cease and desist orders, and authorize staff to investigate some complaints, all as required by the passage of House Bill 1025, 79th Legislature, Regular Session.

The new §277.9 implements a policy that encourages the use of appropriate alternative dispute resolution procedures under Chapter 2009, Government Code, to assist in the resolution of internal and external disputes under the board's jurisdiction as authorized by House Bill 1025, 79th Legislature, Regular Session.

No comments were received regarding adoption of the amendment and new rule.

The amendment and new rule are adopted under the Texas Optometry Act, Texas Occupations Code, §351.151, and House Bill 1025, 79th Legislature, Regular Session (Sections 351.0585, 351.169, 351.2035, 351.2036, 351.205, and 351.608 of the Optometry Act). No other sections are affected by the amendments and new rule.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession, and House Bill 1025, as requiring the staff to report on complaints, requiring the agency to classify complaints according to the categories, requiring two board members to investigate complaints that directly relate to patient care and the investigation or disposition of which do require expertise in optometry or therapeutic optometry, requiring agency to classify inspection violations as complaints, authorizing the agency to issue cease and desist orders, giving authority to agency staff to investigate some complaints, and requiring the agency to implement a policy that encourages the use of appropriate alternative dispute resolution procedures.

§277.1. Complaint Procedures.

(a) Filing complaints. Complaints may be filed in writing with the agency, either in person at the board's office, or by mail. The board shall adopt a form as its official complaint form which shall be maintained at the board's office for use at the request of any complainant. At a minimum, all complaints shall contain information necessary for the proper processing of the complaint by the board, including, but not limited to:

(1) complainant's name, address, and phone number;

(2) name, address, and phone number of the optometrist, therapeutic optometrist, or other person, firm, or corporation, if known;

(3) date, time, and place of occurrence of alleged violation;

(4) complete description of incident giving rise to the complaint; and

(5) express authorization to release patient records to the Board where applicable.

(b) Classification of Complaints. All complaints received shall be sent to the executive director. The board shall distinguish between categories of complaints as follows:

(1) non jurisdictional. If possible, these complaints shall be referred to an agency having jurisdiction over the complaint.

(2) jurisdictional, requiring expertise of a licensee board member to resolve. The Board shall further classify these complaints according to the schedule in subsection (c) of this section. These complaints shall be processed according to subsection (d) of this section.

(3) jurisdictional, concerning matters other than those requiring professional expertise of a licensee board member. The Board shall further classify these complaints according to the schedule in subsection (c) of this section. These complaints may be processed according to subsection (e) of this section.

(c) Classification of Jurisdictional Complaints. All jurisdictional complaints shall be classified in one of the following categories:

(1) Complaints of high priority. This includes, but is not limited to, complaints alleging:

(A) professional misconduct,

(B) qualifications of applicants or licensees,

(C) unauthorized practice;

(D) other acts or the failure to act that potentially threatens the public health, and

(E) a violation of the professional standard of care. The processing of these complaints shall have priority over normal priority complaints. The Board shall evaluate complaints of high priority to determine whether an emergency temporary suspension shall be sought under §277.8 of this title (Rule 279.8).

(2) Complaints of normal priority. This includes, but is not limited to, complaints alleging:

(A) advertising violations,

(B) violations of the Act or Board Rules resulting in economic harm, and

(C) violations of the Act regarding notice that do no potentially threaten the public health.

(d) Investigation-Enforcement Committee.

(1) Makeup of Committee. The chair shall appoint a committee to consider all complaints classified under subsection (b)(2) of this title and complaints referred from Board staff. The committee shall be known as the investigation-enforcement committee and shall be composed of board members who are licensed optometrists or therapeutic optometrists. The executive director shall divide the state into geographic areas, with each member of the investigation-enforcement committee being assigned areas of responsibility within such geographic areas. Two members shall be charged with the responsibility of enforcing the provisions of the Act within the assigned area and are authorized to initiate investigations. The executive director shall supervise all investigations. If, as a result of an investigation within a geographic area, including an inspection of a facility or record, a complaint is filed against a licensed optometrist, therapeutic optometrist, or other person, firm, or corporation by the investigator, the members charged with that area shall assist in the handling of the prosecution of such complaint and disciplinary proceeding, if any.

(2) Authority of Committee. The executive director shall forward a complaint classified under subsection (b)(2) above to the committee members assigned to the area of the complaint unless in the judgment of the executive director, unusual circumstances exist such that it is more appropriate that the complaint be under province of another member. The investigation-enforcement committee, or any member thereof, shall have the power to issue subpoenas and subpoenas deuces tecum to compel the attendance of witnesses and the production of books, records, and documents, to issue commissions to take depositions, to administer oaths and to take testimony concerning all matters within the assigned jurisdiction. In addition to subpoena power, each member of the committee may authorize the executive director to investigate an alleged violation.

(3) Disposition of Complaint. On receipt of the complaint, the members shall determine:

(A) whether to dismiss the matter and take no further action;

(B) whether to send a letter to the person charged reciting that a complaint has been received and that while the investigating member cannot determine or pass upon the merits of the complaint without conducting further investigation that the subject of the complaint be asked to review the complaint to ensure that the Act is being complied with, and that if the allegations are true, to cease and desist from the alleged violations or words to that effect;

(C) whether to conduct further investigations, including conducting investigational hearings or informal conferences;

(D) whether to forward to the board the members' determination that a violation of the Act may have occurred together with a recommendation that proceedings be instituted with the State Office of Administrative Hearings to consider disciplinary action, sanctions, administrative penalties, issuance of cease and desist orders, or refusal to issue a license;

(E) whether to forward to the board the members' determination that some person, firm, or corporation may be practicing optometry without a license or otherwise violating the provisions of the Act, along with the members' recommendation that the board notify the attorney general or appropriate district attorney with accompanying request that appropriate action be taken in accordance with law; and

(F) whether to forward to the executive director the members' determination of findings applicable to subparagraphs (D) and (E) of this paragraph for assessment of administrative penalties.

(G) Should the members of the committee disagree on the disposition of the complaint, the members shall schedule an informal conference.

(e) Complaints Investigated by Staff. Board staff may investigate complaints that do not directly relate to patient care and the investigation or disposition of which do not require expertise in optometry or therapeutic optometry. The investigation may employ members of the Investigation-Enforcement Committee to assist with the investigation as authorized by subsection (d)(2). A complaint shall be directed to the Investigation-Enforcement Committee if the executive director determines that the complaint should not be dismissed or settled or the executive director is unable to reach an agreed settlement.

(f) Request for Information. The committee or board staff may request that the subject of a complaint respond in writing to the allegations in the compliant. The subject of the complaint shall have 14 days from the receipt of the Board's request to respond. The executive director may extend the time period upon a showing of good cause by the subject of the complaint.

(g) Dismissal and Tracking of Complaints. A complaint shall not be dismissed without appropriate consideration. The board and complainant shall be advised of complaint dismissals. A complaint dismissed by the executive director shall be approved by the Board at a Board Meeting. The executive director shall make a report at each board meeting regarding complaints to the Board.

(h) Basic Competence Violations.

(1) If during the investigation of an optometrist's or therapeutic optometrist's compliance with Section 351.353 of the Act and §279.7 of this title, the optometrist or therapeutic optometrist fails to complete all the of required findings in an initial examination, the com-

pleted report of investigation will be classified as an complaint and forwarded by the executive director to the committee members.

(2) In determining the action to take under subsection (d)(3), if any, the committee members shall consider the seriousness of the omitted finding, the compliance history of the optometrist or therapeutic optometrist, and prior actions of the board concerning similar complaints. Omission of four or more basic competency findings requires the committee members to conduct an informal conference.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505291
Chris Kloeris
Executive Director
Texas Optometry Board
Effective date: December 6, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 305-8502

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CHAPTER 279. INTERPRETATIONS

22 TAC §279.2

The Texas Optometry Board adopts amendments to §279.2 without changes to the proposed text published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5535).

The amendments revise those sections of the rule in conflict with House Bill 1025, 79th Legislature, Regular Session, by requiring release of a contact lens prescription at the completion of the examination, and setting out the duties and requirements for verifying a contact lens prescription.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Optometry Act, Texas Occupations Code, §351.151, and the Contact Lens Prescription Act, Texas Occupations Code, §§353.002, 353.005, 353.1015, 353.101, 353.104, 353.152, 353.156, 353.158 and 353.204 as amended or added by House Bill 1025, 79th Legislature, Regular Session, and federal law, 15 U.S.C. Sections 7601 - 7610. No other sections are affected by these amendments.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession. The Board interprets House Bill 1025 to require licensees to issue contact lens prescriptions at the completion of a contact lens exam and to verify prescriptions when requested by a dispenser authorized by the patient to obtain the verification, and requires the agency to adopt rules. Section 353.204 authorizes the agency to discipline optometrists and therapeutic optometrists for violations of the Contact Lens Prescription Act. The agency interprets the requirements of 15 U.S.C. Sections 7601 - 7610 to be similar to the requirements of House Bill 1025.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505292
Chris Kloeris
Executive Director
Texas Optometry Board
Effective date: December 6, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 305-8502

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 10. WORKERS' COMPENSATION HEALTH CARE NETWORKS

The Commissioner of Insurance adopts new §§10.1, 10.2, 10.20 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.86, 10.100 - 10.104, and 10.120 - 10.122 (collectively referred to as Chapter 10), concerning workers' compensation health care networks. Sections 10.1, 10.2, 10.20 - 10.22, 10.24 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.83, 10.85, 10.101 - 10.104, 10.121, and 10.122 are adopted with changes to the proposed text as published in the September 2, 2005, issue of the *Texas Register* (30 TexReg 5287). Sections 10.23, 10.84, 10.86, 10.100 and 10.120 are adopted without changes.

These new sections are necessary to implement Article 4 of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. Article 4 of HB 7 is cited as the Workers' Compensation Health Care Network Act and codified at Texas Insurance Code Chapter 1305 (the Act).

Under HB 7, the 79th Legislature directed the commissioner of insurance to adopt rules as necessary to implement the Act not later than December 1, 2005. Further, the Legislature directed the department to accept applications from a network seeking certification under the Act beginning January 1, 2006. These new sections will be applicable on January 1, 2006.

Pursuant to HB 7, the Texas Workers' Compensation Commission was abolished, and all functions of the Texas Workers' Compensation Commission were transferred to the newly created Division of Workers' Compensation at the Texas Department of Insurance (the department), effective September 1, 2005. Where appropriate for purposes of this order, references to the former Texas Workers' Compensation Commission shall be referred to as "the TWCC," and references to the Division of Workers' Compensation will be referred to as "the Division."

The Act authorizes insurance companies; certified self-insurers for workers' compensation insurance; certified self-insured groups under Labor Code Chapter 407A; and governmental entities that self-insure, either individually or collectively (all the preceding collectively referenced in these sections as "insurance carriers"), to establish or contract with certified networks for the delivery of health care services to injured employees of employers who elect to receive workers' compensation coverage through networks. Under the Act, if the employer elects workers' compensation network coverage, the employer's injured employees who receive workers' compensation coverage

and who live within the network's service area must obtain medical treatment for a compensable injury within the network, except under certain specified circumstances. Injured employees who live within the service area of a network and who are being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with a network must select a network treating doctor, or under specified circumstances, the employee's health maintenance organization (HMO) primary care physician or provider who agrees to serve as a network treating doctor, upon notification by the carrier that health care services are being provided through a network. Further, the Act outlines standards for the certification, administration, evaluation, and enforcement of the delivery of health care services to injured employees by networks contracting with or established by workers' compensation insurance carriers.

Chapter 10 establishes standards and requirements applicable to networks, insurance carriers, other persons, and third parties operating under the Act. The standards and requirements relate to network certification; contracting; notice; plain language; selection of a treating doctor; dispute resolution related to whether an employee lives within the network service area; network operations; utilization review; retrospective review; and complaints. The adopted sections should be read in conjunction with the Act; Insurance Code Chapter 5, Subchapter D; and Labor Code Title 5 and related rules; and other statutes and rules, as applicable.

This adoption reflects the department's efforts to address concerns necessary to implement the Act at this time. The department recognizes that additional rulemaking may be necessary in the future to address ongoing concerns that have been or will be raised regarding implementation of the Act as networks become certified and operational.

Changes have been made to the proposed sections as published; however, none of the changes introduce new subject matter or affect additional persons other than those subject to the proposal as originally published. Throughout the adopted rule, the department has made editorial and grammatical changes for ease of reading and clarity and, where necessary, corrected punctuation, references and typographical errors.

The "Live" Issue. In developing these rules, the department considered the issue of what constitutes where an employee lives for the purpose of establishing the applicability of network requirements to a particular employee. Insurance Code §1305.005(i) and §1305.007 give the commissioner rulemaking authority to implement Chapter 1305 to address this issue for employees who live outside network service areas. The department added language to the definition in proposed §10.2(a)(14)(A) that incorporates the presumption, found in the rule at §10.61(b), that the address the employee provides to the employer is where the employee lives. Using this address is the best available method for initially identifying where an employee lives and establishing a baseline that will be available to employers who are charged with delivering notices of network requirements that may be region-specific. There are circumstances that will require a more thorough analysis of where a particular employee lives under the requirements of these rules, and the rules take these circumstances into account by retaining the flexibility provided in the proposed definition and by indicating that an employee may also establish that the employee temporarily lives in another location due to a work assignment or to receiving necessary assistance with the routine daily activities of living. Providing for a temporary change in where an employee lives is an important element of the definition due to the nature of some jobs that require frequent or lengthy temporary assignments away from an employee's principal legal residence. In such a circumstance, the employee should be able to receive necessary health care despite the employee's temporary location outside the network. Likewise, there are times when an injured employee may require assistance with routine daily activities and choose to receive this convalescent care from a family member that resides outside the network's service area. The employee will need the ability to receive health care services from providers near this temporary location, and the rule enables this by establishing the new location as the place where the employee lives during that time. Although some interested parties, as indicated in the comments, contend that these temporary locations are potential loopholes for fraudulent employees or providers, the absence of this allowance in the rule would operate as an unreasonable restriction on an employee's right to receive health care services for a compensable injury. Additionally, recognition of the temporary locations where an employee may live allows the employee to receive necessary care while away from the legal residence, thus furthering the goal to return the employee to work efficiently and expediently. Conversely, a delay in care while an employee is away from the employee's legal residence may delay an injured employee's return to work. Furthermore, unnecessary delay of care punishes an employee who is attempting to return to a job that requires temporary assignments to new locations and an employee who is attempting to recover from an injury in order to return to work. By including a mechanism through which a carrier may contest an employee's assertion that the employee lives outside the network, the adopted rule strikes a balance between avoiding potential fraud and delivering necessary care to an employee who is forced to temporarily relocate. A carrier may also establish multiple service areas or contract with multiple networks in such a way that much of the state is covered by an applicable network service area. This will allow carriers and employers to make use of the network model for more employees and in more circumstances so long as the employees are given appropriate notice of the applicable network.

Treatment Guidelines. The department has changed the rule in §10.42(b) and §10.101(b) to require networks and carriers to be flexible enough to allow deviations from network treatment guidelines. New §10.42(b)(3) requires provider contracts to include a statement that the insurance carrier or network may not deny treatment solely on the basis that a treatment for a compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network. Section 10.101(b) was changed to reference a carrier's retrospective review program in addition to a carrier's utilization review program such that a carrier may choose to use a pre-service or post-service process for a treating doctor or specialist to request approval from the network for deviation from treatment guidelines, return-to-work guidelines and individual treatment protocols where required by the particular circumstances of an employee's injury. The department acknowledges that a deviation procedure is necessary, and the change to the language allows networks the flexibility to design their own procedures. The statute, at Insurance Code §1305.304, requires networks to adopt treatment guidelines. Insurance Code §1305.152(c)(2) requires that the guidelines be made applicable to providers through the network-provider contract. The statute does not address deviations from treatment guidelines, but the commissioner may specifically address the issue through the rulemaking and implementation authority provided at Insurance Code §1305.007. In doing so, the department considered

that the statute prohibits a carrier from denying payment for a particular treatment solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or the network. The department also considered that carriers are given latitude as to the use of preauthorization requirements and that requiring pre-service approval of deviations could impact the basic model of a network that declines to make extensive use of preauthorization requirements. As a result, carriers and networks can design their procedures such that the carrier may engage in retrospective review of the deviation, but any objection to the deviation must be based on something more than the fact that the treatment was not addressed in the treatment guideline. The department anticipates that this will most likely take the form of a denial based on the medical necessity of the services. The department has therefore made the deviation process a part of the utilization and retrospective review procedures. In evaluating a request for deviation, carriers cannot rely strictly on any applicable screening criteria, as screening criteria will necessarily be consistent with the treatment guidelines from which the provision is requesting deviation.

Notice of Network Requirements. In proposed §10.60(a), (a)(1), (a)(2), and proposed §10.61(f)(4), in response to comments and for clarification, the department has deleted specific references to subsections (d), (e) and (g) of Insurance Code §1305.005. These changes clarify that every employee should receive an initial notice of network requirements and a notice at the time of injury. It is not sufficient for an employer to provide an employee with only the initial notice, even if the employer obtains a signed acknowledgement from the employee at that time. This requirement is consistent with the statutory requirements and gives an injured employee the best opportunity to be fully aware of the network requirements and the most current information regarding network configuration and available providers. A notice is not effective unless it is accurate, appropriate and sufficient to alert an employee to the existence of a network or network service area in which the employee lives. Thus, there is a two-prong test for determining whether an employee will be required to receive care pursuant to a carrier's network requirements. Under the test, an employee must live within a service area and must receive notice of network requirements that is applicable to the employee's location. The department received numerous comments regarding the potential for a carrier's use of multiple networks encompassing several different service areas and regions. Other commenters were concerned that large networks with multiple service areas would be forced to provide voluminous notices that applied to the entire state despite the practical reality that the coverage was issued to a regionally specific employer. Under the rules, a notice of network requirements may be limited to a specific region. Additionally, the department understands that insurance carriers and employers are given the flexibility to contract for very limited or expansive networks that may be offered by or through a carrier. However, carriers and employers should be aware that employees will be required to comply with only those network requirements of which they have received notice. For those employees who live outside the service area or areas described in the notice, the network requirements will not apply. This is true without regard for whether there is an alternate service area or network, unless the notice of that service area or network is subsequently delivered to the employee. For employees who are frequently away from the employer's regional area due to temporary work assignments, the best way for an employer or carrier to take advantage of large or statewide networks with multiple service areas is to provide notice of any and all applicable service areas. Although the rule does allow a carrier to provide notice of an alternate service area during the process of determining whether an employee lives outside a service area, the notice of the alternate service area is subject to the same basic principle that network requirements are not applicable until the employee has received an appropriate notice. This approach allows carriers and employers to be aware of which requirements apply to employees. Similarly, it provides an assurance that employees will not be held liable for out-of-network services received by an employee who had no knowledge of the network requirements.

Use of Electronic Means. The adopted rule includes changes to proposed §10.60(f) to clarify that electronic signatures are acceptable and acknowledgment of notice requirements may be accepted by electronic means. This should allow employers and carriers to take advantage of the ease and expediency afforded by allowing their employees to provide a signature by electronic means. Additionally, the adopted rule also includes changes to §10.60(c) to provide that employers and carriers may issue electronic notices of network requirements, including provider directories, provided that paper copies are available upon request.

Sample Acknowledgment Form. The rules include reference to a sample acknowledgment form that carriers and employers may obtain from the department's website. The sample is not mandatory, but is provided as an effort by the department to better facilitate an employer's efforts to comply with the rule. Carriers and employers may use the sample form, modify the sample form appropriately to suit their needs, or use another employee acknowledgment form that complies with the requirements contained in §10.60(d)(2).

Subchapter A. The department has added a severability clause as new subsection (e) to proposed §10.1, which provides that if a court of competent jurisdiction holds that any provision of this chapter is inconsistent with any statutes of this state, is unconstitutional, or is invalid for any reason, the remaining provisions of Chapter 10 shall remain in full effect. This provision is necessary to clearly state the department's intent. The department has clarified in proposed §10.2(a)(18) that an organization that is formed to arrange for health care services to injured employees is a workers' compensation health care network if it meets the remaining elements set forth in the definition. This clarification is consistent with Insurance Code §1305.101, which provides that "...a network shall provide or arrange for health care services...."

Subchapter B. In response to a comment, the department has deleted proposed §10.20(b) as unnecessary. Accordingly, numbering changes have been made within §10.20. The department has also changed proposed §10.20(a)(2) (§10.20(2) as adopted) in response to a comment to clarify that the section applies only to those entities that provide workers' compensation health care network services. In proposed §10.21(c), the department corrected the HMO Division mailing address. In response to comments that the proposed financial reporting requirements for networks are overly burdensome, the department deleted the requirement in §10.22(7) that networks provide a statement of equity to reduce the burden of providing detailed financial information for non risk-bearing entities. The department notes, however, that the commissioner retains the authority under the Insurance Code to request such information. In proposed §10.22(13) the department deleted the requirement that network applications include pro forma financial projections and substituted a requirement that networks provide projections for anticipated revenue and profitability for the first two years

of operation after certification. In response to comments, the department added to proposed §10.22(14) an exemption from the requirement that network applications include a financial authorization form to lessen the burden for applicants who are licensed, risk-bearing entities because these entities' assets have already been subject to department examination. In proposed §10.22(17), in response to comments, the department has modified the language to require that applicants submit a plan for obtaining certification of provider filings of financial disclosure with the Division. In proposed §10.24(b)(2), the department added the HMO division mailing address for providing the network's financial statement. In proposed §10.25(b)(3) (§10.25(a)(3) as adopted), the department added the phrase "material modification" before "network configuration" to clarify that networks need prior approval of material changes to network configuration. In accord with the change to the language in proposed §10.22(13), the department changed §10.26(b)(3) to correct a reference from §10.22(7) to §10.22(13), deleted the reference to "pro forma financial statements," and added the word "projections." In proposed §§10.25, 10.26, and 10.27, the department added language in response to comments to clarify that networks do not need to file an entire application each time they report information that amends their initial network application. In proposed §10.25(a) (§10.25(b) as adopted), the department revised the language to state that a network shall file any information other than the information in subsection (a) of this section that amends, supplements, or replaces the items required under §10.22 of this chapter, which information must be filed no later than 30 days after implementation of any change. In proposed §10.26(g)(2) and §10.27(f)(2), the department corrected the HMO Division mailing address. The department changed the language of proposed §10.27(f) to clarify that all network modification request forms, and not only those which relate to network configuration, may be obtained from the same location.

Subchapter C. In §10.40(a) as proposed, the department corrected an incorrect reference in the rule to more accurately reflect the requirement under Insurance Code §1305.102 by changing "in accordance with this chapter" to "by the commissioner in accordance with Insurance Code §1305.102." The department added "as applicable" at the end of proposed §10.41(a)(9) in response to comments to clarify that not all networks will have the delegated responsibility for payment to providers or notification to employees. In proposed §10.41(a)(15)(B), the department added language in response to comment to clarify that complaint logs and complaint files are required to be disclosed to the extent permitted by law. This clarification takes into account that privacy, confidentiality, or security law or other applicable law may prohibit release of certain portions of a complaint log or complaint file. The department changed the language of proposed §10.42(b)(1) in response to comment to clarify that the provision requiring provider contracts and subcontracts to include a hold-harmless clause stating that the provider and provider network will not bill or attempt to collect payment for health care services for compensable injuries from the employee may not apply in some situations as set forth in Insurance Code §1305.451(b)(6). In proposed §10.42(b)(4)(B) (§10.42(b)(5)(B) as adopted), the department changed the "dispute resolution process" to the "complaint resolution process" to accord with the statute. In response to comment, the department has deleted the requirement in proposed §10.42(b)(6)(B) that members of a network's advisory review panel must be network providers and added the requirement that the members be of the same licensure as the provider appealing a termination. In §10.42(b)(6)(G) as proposed, the department has added the words "a provision that" to clarify that network contracts with providers must contain provider termination provisions. The department has restructured provisions of proposed §10.42 and has renumbered remaining provisions accordingly. The department has added new §10.42(b)(14) in response to comment to require that network contracts with providers contain a statement that the provider specifically agrees to provide treatment for injured workers who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party. In proposed §10.42(d), in response to comments, the department removed "any" before "economic problems" to clarify the carrier and network are not required to provide notice each time a utilization management study is performed.

Subchapter D. In §10.60(b), the department made a change to reflect that a carrier must comply with §10.60(c) - (h) when a carrier has an obligation to deliver the notice of network requirements and obtain the signed acknowledgment form. In proposed §10.60(c), the department made grammatical changes relating to the phrase "must be in" for clarification. The rules include reference to a sample acknowledgment form that carriers and employers may obtain from the department's website. Carriers and employers may use the sample form references in §10.60(d)(2), modify the sample form appropriately to suit their needs, or use an employee acknowledgment form that complies with the requirements contained in §10.60(d)(2). In proposed §10.60(d)(2), the department changed the HMO Division mailing address. In proposed §10.60(e)(2)(C), the department added "other than emergency care" to clarify that if the employee seeks health care other than emergency care from someone other than a network provider without network approval, the insurance carrier may or not be liable, and the employee may be liable for payment for that health care. This change is in accord with Insurance Code §1305.006. In proposed §10.60(e)(3), the department changed "living address" to "where the employees" for clarification. In response to a comment, the department clarified in proposed §10.60(f) that a carrier required to provide employee information to an employee under Insurance Code §1305.103(c) and §10.60(b) shall obtain a signed employee acknowledgment form from that employee. In response to comments, the department added language in proposed §10.60(g)(5) to clarify that if it is ultimately determined that the employee lives in the network's service area, there may be some situations in which the carrier is not liable and the employee is liable for the payment of health care services. In response to comments that 21 days is too long for certain injured employees to wait for a referral to a specialist, the department has added language in proposed §10.60(g)(15) to clarify that a network must arrange referrals to specialists within the time appropriate to the circumstances and condition of the injured employee but not later than 21 days after the date of the request. In proposed §10.60(h), the department has added language in response to comment to require that an employer or carrier delivering the notice of network requirements and employee acknowledgment form to employees document the location of the delivery in addition to the delivery method, to whom the notice was delivered, and the delivery date(s). The department also added language to clarify that an employer's or carrier's failure to incorporate mandatory documentation elements into a standardized process for delivering the employee notice of network requirements creates a rebuttable presumption that the employee has not received the notice and is not subject to network requirements. In proposed §10.61(d) and proposed §10.62(e), the department substituted the word "a" for "the" be-

fore "network" for clarification and for consistency with the language in Insurance Code §1305.301(d), which refers to networks establishing one or more service areas within the state. In response to comments, in proposed §10.61(e), the department substituted the word "intentional" for the word "material" before the word "misrepresentation" to clarify that only intentional misrepresentations regarding where the employee lives are at issue in this provision. This change prevents an employee who may make unintentional misrepresentations regarding where the employee lives from being unduly punished for the mistake. In proposed §10.61(f)(4), the department has added the words "and service area" after "the appropriate network," for clarification. In §10.63(b) as proposed, the department has added language in response to comments to clarify that the network certification required in connection with the notice of network requirements and employee information forms under proposed §10.63(b) must be filed with the department only and need not be distributed to every employee enrolled in the network plan.

Subchapter E. In proposed §10.80(b)(7), the department deleted the word "treating" before "doctors" for clarification and in response to commenters who urged that doctors other than treating doctors may assess maximum medical improvement and impairment rating services. In proposed §10.80(h), the department has changed "a skill or specialty" to "skilled or specialty care" for clarification. In response to comment, the department changed the language of proposed §10.81(b)(2)(B)(vii) to "provider billing and provider payment processes, if applicable" to require the annual quality improvement work plan to include both the provider billing and provider payment processes. In proposed §10.81(c)(1), the department deleted the language "or any other national accreditation entity recognized by rules adopted by the commissioner of insurance" because the department has not recognized any other national accreditation entity recognized by rules adopted by the commissioner. In proposed §10.81(g), the department added language in response to comment to allow for a temporary phase-in of case management certification requirements. The department modified requirements set forth in proposed §10.82(a)(1)(B) in response to comments that the requirement for a network to verify the status of financial disclosure filings for each provider in the network is overly burdensome and costly. In §10.82(a)(1)(B), the department deleted the requirement that networks develop written procedures for verifying that the provider filed financial disclosure information with the Division and added language that provides that written procedures for verifications shall instead include certification by applicants of completion of required maximum medical improvement and impairment rating training and filing financial disclosure. Further, in §10.82(a)(1)(B) as proposed, the department added language requiring networks to make available to network providers or applicants, upon request, all credentialing criteria and procedures. In proposed §10.82(a)(1)(B)(viii), in response to comments, the department deleted unnecessary language. In proposed §10.82(a)(1)(C), the department has added new clause (vi), which contains language allowing networks to phase in required site visits to treating doctors until not later than the first anniversary after the date of the network's certification and details certain other requirements. Additionally, the new clause provides that if the department receives a complaint about a treating doctor who has not had a site visit, the network is to perform the site visit not later than 30 days after notification by the department of the complaint, unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found. In §10.82(a)(1)(E)(iv), (a)(1)(E)(v) and (a)(1)(F) as proposed, the department deleted references to institutional providers and substituted the words "health care facilities" for clarification and consistency with other language in the rule. In proposed §10.81(a)(2)(E)(iii), the department added "compliance with" before "other applicable state or federal requirements" to clarify the contents of the credentialing process for health care facilities and changed Texas Department of Mental Health and Mental Retardation to the Texas Department of State Health Services to reflect an organizational change. In proposed §10.82(d)(2), the department deleted two references to "NCQA" and added the phrase "one of the national accreditation organizations as described in §10.81(c) of this subchapter (relating to Quality Improvement Program." for clarification that entities may be accredited by national accreditation organizations other than the NCQA in accordance with §10.81(c). In proposed §10.83(c), the department substituted the word "accessible" for "available" to emphasize that networks are to allow providers ready access to treatment guidelines. In response to comments, the department corrected a minor grammatical error in proposed §10.85(d) by changing "a" to "an" before the word "employee's." In proposed §10.85(d), the department revised the language specifying how an employee who is a member of an HMO at the time of the employee's injury may request that the employee's HMO primary care physician or provider also serve as his treating physician under Insurance Code Chapter 843, as the terms "physician" and "provider" are defined in that chapter. Additionally, the department has added "as applicable to treating doctors" in the last sentence to clarify that treating doctors need only abide by the rules that apply to them.

Subchapter F. In response to comments, the department modified proposed §10.101(b) to require that the carrier's utilization review program and retrospective review program include a process for a treating doctor specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

In response to comment, in proposed §10.102(c)(4), the department deleted "and a validation that the provider is licensed in accordance with Labor Code §408.0231(b)" because the department does not have authority to require Texas licensure for providers involved in utilization review. In response to comment, in proposed §10.102(g), the department deleted two references to "retrospective review" because the language addressing the timeline requirements for retrospective review are addressed in new §10.102(h). In new §10.102(h) and in response to comments, the department added language related to adverse determinations made pursuant to retrospective review which requires the adverse determination to be issued in response to a claim for payment consistent with the timelines set forth in Labor Code §408.027 related to payment of health care to providers. In proposed §10.103(a)(4)(B)(iv), the department corrected a reference by deleting a reference to §10.102(h) and adding a reference to §10.102(i). The department deleted proposed §10.104(i) which provided that judicial review shall be conducted in the manner provided for judicial review of contested cases under the Government Code because this requirement is not in Insurance Code Chapter 1305.

Subchapter G. In proposed §10.121(c), in response to comments requesting clarification concerning whether the term "days" in Subchapter G means business days or calendar days, the department has added the word "calendar." In proposed

§10.122(b)(2), the department corrected the HMO Division mailing address.

Fees and Documentation. The provisions of Insurance Code Chapter 1305 clearly allow the networks to contractually negotiate fee reimbursement and do not adopt the Division of Workers' Compensation fee guidelines. Likewise, any documentation requirements dictated by the Division of Workers' Compensation fee guidelines do not apply to networks. The department encourages networks, carriers, and providers to address any documentation requirements during the contract negotiation process. These discussions provide an excellent opportunity to ensure claims management needs are met, while decreasing the likelihood of administrative hassles associated with document submission.

Division Responsibilities Within the Department. With the implementation of the network infrastructure, it is necessary that different divisions within the department, depending on the specific subject matter, handle the various operational responsibilities. For example, the department's HMO Division will handle complaints related to provider adequacy issues within a network, but disputes regarding the entitlement to travel reimbursement associated with securing healthcare within a network will be handled by the Division of Workers' Compensation. The source of the statutory authority is a simple indicator of the responsible division (Insurance Code provisions are generally handled by the HMO Division and Labor Code provisions are generally handled by the Division of Workers' Compensation). All divisions within the department will be working closely together to minimize any potential problems created by this regulatory scheme, including, where appropriate, revising existing processes, organizational responsibilities, and rules.

Subchapter A contains general provisions and definitions regarding this chapter. Section 10.1 explains the purpose and scope of this chapter. Section 10.2 defines certain terms used in this chapter.

Subchapter B describes the process for the certification of workers' compensation health care networks. Section 10.20 provides that certification under Insurance Code Chapter 1305 and the other provisions of Chapter 10, except under certain circumstances, is a requirement for operating a workers' compensation health care network. Section 10.21 sets forth the requirement that a verified certificate application must be filed on prescribed forms accompanied by a non-refundable application fee and describes where to obtain the prescribed forms for the certificate application from the department. Section 10.22 lists the requirements for the contents of the certificate application. Section 10.23 provides that the commissioner will approve or disapprove an application for certification of a network in accordance with Insurance Code §1305.054. Section 10.24 lists the financial information that certified networks must provide to the department and carriers with which the network contracts. Section 10.25 lists the filing requirements for networks after issuance of the network's certification and requires that the network file with the department a written request for approval before making certain changes. Section 10.26 sets forth the requirements for modification to a network's service area and specifies the associated information a network must provide to the department for prior approval when it modifies a service area. Section 10.27 provides the requirements for modification to a network's configuration, including filing a modification request with the department for prior approval.

Subchapter C contains information regarding the contracting requirements for workers' compensation health care networks. Section 10.40 states the requirements for management contracts for networks. Section 10.41 states the requirements for contracts between networks and insurance carriers. Section 10.42 states the requirements for contracts between networks and providers.

Subchapter D details various network requirements. Section 10.60 specifies notice of network requirements and employee information, which include both the notice of network requirements, employee information and the employee acknowledgment form. This section also sets forth the notice and acknowledgment form requirements, such as standards for language and readability. Section 10.61 specifies requirements for employees who live within the network's service area and specific information related to employee access and insurance carrier liability for health care. Section 10.62 outlines the dispute resolution process for an employee who asserts that he or she does not currently live in the network's service area. Section 10.63 specifies the plain language and other requirements for the notice of network requirements, employee information, and employee acknowledgment form.

Subchapter E lists network responsibilities related to network operations. Section 10.80 outlines the accessibility and availability requirements for networks and network providers. Section 10.81 describes the mandated quality improvement program for monitoring and evaluating the quality and appropriateness of health care and network services. Section 10.82 outlines the credentialing process required for network doctors and health care practitioners. Section 10.83 addresses treatment guidelines, return-to-work guidelines, and individual treatment protocols for network care. Section 10.84 specifies compliance requirements for treating doctors. Section 10.85 provides for an employee's selection and change of a treating doctor. Section 10.86 specifies the criteria for a network's required establishment and maintenance of telephone access logs.

Subchapter F sets forth the utilization review and retrospective review requirements for networks, including requirements that represent areas of conflict between the Act and Insurance Code Article 21.58A. Section 10.100 applies Insurance Code Article 21.58A to utilization review conducted in relation to claims in a workers' compensation network and, provides that in the event of a conflict, the requirements of the Act apply. Section 10.101 requires that screening criteria used for utilization review and retrospective review related to network health care must be consistent with the network's treatment guidelines, return-to-work guidelines and individual treatment protocols and must include a process requiring a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, screening criteria and individual treatment protocols, as applicable. Section 10.102 establishes notice requirements for persons performing utilization review or retrospective review for an injured employee receiving health care services in the network. Section 10.103 sets forth standards for reconsideration of adverse determinations, including requirements for maintaining and making available a written description of the reconsideration procedures involving an adverse determination. This section also requires that the reconsideration procedures be reasonable and contain certain provisions. Section 10.104 specifies the various procedural requirements for an injured employee, person(s) acting on behalf of an injured employee, or an injured employee's requesting provider seeking independent review of adverse determinations. Among other requirements, the section provides

that the department shall assign the review request to an independent review organization, and that the insurance carrier shall pay for the independent review provided under this subchapter.

Subchapter G describes requirements relating to complaints. Section 10.120 requires each network to implement and maintain a complaint system that provides reasonable procedures for resolving oral or written complaints. Section 10.121 establishes requirements for complaints and deadlines for responses and resolutions. Section 10.122 provides for filing complaints with the department. Persons who are dissatisfied with the resolution of complaints by the network may file a complaint with the department on forms that may be obtained from the department's website of from the HMO Division.

General: A commenter notes that network mandates should be subject to careful cost-benefit analysis so that any mandates do not compromise the ability of networks to deliver cost-effective, high quality care.

Agency Response: The department generally agrees with the commenter's concern.

General: A commenter requests additional language in the rule relating to the value that third party processors can bring to the system that would specifically allow employers and health care providers to contractually assign or outsource claims processing, billing, collections, or fulfillment of benefits or services deemed medically necessary and appropriate and delivered through workers' compensation networks.

Agency Response: The department declines to change the rule. Except for certified self-insured employers who are "insurance carriers," Chapter 1305 and the rules do not address an employer's authority to delegate or outsource functions. With regard to providers, Insurance Code §1305.152(c) and §10.42(b) allow for network contracts with providers to include subcontracts which meet the requirements of the statute and rule. The department sees no need to adopt additional language that would specifically allow health care providers to contractually assign or outsource "fulfillment of benefits or services deemed medically necessary and appropriate and delivered through workers' compensation networks." Except for the amount of reimbursement determined by the contract between the network and providers, billing by and reimbursement to providers is subject to the requirements of the Texas Workers' Compensation Act as set forth in Insurance Code §1305.153(d). Labor Code §413.011(a) and §413.053 authorize the commissioner of the Workers' Compensation Division to adopt rules relating to billing and health care reimbursement.

General: A commenter is concerned with the complexity of TWCC's forms and suggests, that to reduce the cost of workers' compensation coverage, the state should simplify the paperwork, hold both payer and providers to the contracts, and penalize the outliers. The commenter states that payer plans often delay, deny or mispay claims. Currently, if a physician remains out of network, he can receive 125% of Medicare. If providers are paid within 30 days of receipt of a clean claim, then 115% of Medicare would be a reasonable reimbursement.

Agency Response: The department appreciates the comment. Future rulemaking by the Division may address the administrative issues identified by the commenter and will be a more appropriate forum for these concerns.

General: A commenter is concerned about what providers the networks are going to try to exclude and why, and suggests that there should be an equal playing field for participants who are qualified and willing to play by the rules.

Agency Response: The department notes that, under Insurance Code §1305.152(b), a network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in Chapter 1305 for participation if the network determines that the network has contracted with a sufficient number of qualified health care providers.

General: A commenter questions who is going to make the determination of adequate care.

Agency Response: Insurance Code Chapter 1305 includes checks and balances for the determination of adequacy of care. The network initially determines adequacy of care because the network is responsible for contracting with providers for the provision of health care and performing functions related to the operation of a quality improvement program and credentialing in accordance with applicable statutes and rules. If the department determines that the network does not meet the adequacy of care requirements of the statute, the department will take appropriate action, including disciplinary action against the carrier, the network or both.

General: A commenter appreciates the hard and good work done by the department regarding HB 7.

Agency Response: The department appreciates the comment.

General: A commenter handles claims on behalf of insolvent property casualty carriers, including workers' compensation carriers, and suggests inserting an insolvency clause regarding what happens in the event that the carrier becomes insolvent and the carrier is utilizing a network.

Agency Response: HB 7 and these rules do not directly address the insolvency of an insurance carrier. Adding this subject matter to the rule would be a substantive change and would not allow all interested stakeholders to comment on the change.

General: A commenter thinks the proposed rule is very good and is very excited about it. The commenter notes that case management and utilization review are important components of any certified network program and need to be integrated within the network; that providers that have the right outcomes and the right focus need to be identified, and that networks that file for certification need to have the right mix of physicians.

Agency Response: The department appreciates the comment.

General: A commenter requests that the department add outpatient therapy centers at page 12, line 22.

Agency Response: The department is unable to locate the specific provision which the commenter references using the page and line numbers provided in the comment. The department has searched various versions of the proposed rule, including the informal draft, the *Texas Register* proposal, and the electronic document on the department's web site.

General: A commenter has concerns about how providers are going to know when a patient schedules an appointment or comes into their office if the $7,000 threshold regarding carrier liability for health care provided has already been met. The commenter requests that the workers' compensation system include some type of documentation to determine if the $7,000 threshold has already been met.

Agency Response: The proposed rule does not address this issue. The department believes that any change to the rule in response to these comments would be a substantive change to the rule and would not allow all interested stakeholders to comment. The department notes that once a network provider receives notification under Insurance Code §1305.153(e) that a carrier is contesting compensability, the provider may contact the carrier to see if the $7,000 has already been met.

General: A commenter is concerned about the effect that the effective date of the rules will have on employers no longer in business, but with whom a carrier still has a bona fide active claim, or employers who have changed carriers and are using a different network than the carrier is using and leaving the carrier stuck with that claim as an active claim. Another commenter states that there should be some protection for the networks if they have set up treatment protocols and a program on how to deal with old claims so that there is no increase in litigation.

Agency Response: Section 10.60(b) provides that an injured worker will receive a notice of network requirements from a carrier that is responsible for a particular injured worker's claims. This will not have an effect on an employer, as coverage for the injury is the responsibility of the carrier. Existing claims from an injured worker may not be appropriate for a network's treatment guidelines, as the guidelines do not apply retroactively. New claims that are the result of an existing injury will be subject to network treatment guidelines, but may be appropriate for a deviation from the guidelines if the established course of treatment is inconsistent with the network's guidelines.

General: A commenter requests clarification on whether required medical examiners can participate in the network. It is the commenter's understanding that with the elimination of the designated doctors' list, medical disputes are referred back into the network to be evaluated by a network provider other than a designated provider or treating doctor. The commenter understands that additional rules will be forthcoming but desires initial clarification to ensure proper development of the network.

Agency Response: Labor Code §408.004(f), as amended by HB 7, specifically excludes the use of Required Medical Examinations (RMEs) to determine the appropriateness of health care provided through a workers' compensation health care network established by Chapter 1305, Insurance Code. HB 7 did not eliminate the designated doctors' list, but rather added new issues to the list of issues the designated doctor may address under Labor Code §408.0041 (including issues related to an injured employee's ability to return to work, the extent of the employee's compensable injury, and whether the injured employee's disability is a direct result of the work-related injury). Additionally, HB 7 allows the use of designated doctors to resolve disputes regarding the issues listed in Labor Code §408.0041 for network claims. However, Insurance Code §1305.101(b) does prohibit a network doctor from serving as an RME or designated doctor for an injured employee who is being treated by the same network in which the doctor also participates. Additionally, regardless of whether an injured employee is receiving medical care by a network certified under Chapter 1305, medical disputes related to prospective and retrospective medical necessity denials will be handled by independent review organizations (IROs) licensed by TDI.

Transition: A commenter has various concerns about the overall transition to the network, including the waiting period from the time that the network is approved until the time the actual network goes into effect, and wants to know who is going to notify the employees about the transition and explain issues including the provision being made for continuity of care. Another commenter suggests the department's educational outreach might include: (1) some language in the proposed rules; (2) education of the division by different stakeholders; (3) a commissioner's bulletin, and (4) Fastfax.

Agency Response: The department plans to address the commenters' concerns through an upcoming education program and other means such as FAQs, as one commenter suggests.

Electronic Submission and Processing of Claims: A commenter participates with a number of organizations in electronic processing of claims and bills and would be happy to help share some of that information. Another commenter supports electronic claims in Texas workers' compensation as a huge cost saver to the system. Another commenter supports electronic means of credentialing rather than paperwork. One commenter states that paperwork and forms and lack of electronic claims are a problem. The commenters note that for HMOs and PPOs it is very important that providers submit claims and any additional documentation such as forms electronically because it saves so much money in the system. The commenter encourages the exploration of current capabilities that exist in the TxComp system and how the providers, carriers and other stakeholders can access the TxComp system.

Agency Response: The department appreciates the comment. HB 7 §8.008 requires the commissioner of workers' compensation to adopt rules regarding electronic billing requirements under Labor Code §408.0251. The department will share these comments, including the comment regarding the TxComp system, with the Division, which administers the TxComp system.

Prompt Pay and Fraudulent Claims: A commenter requests that in cases of fraud with multiple red flags, carriers need an exception from the prompt pay rules. The commenter adds that prompt pay deadlines may impede a fraud investigation because sometimes it takes longer than the prompt pay rules allow to investigate a claim in order to actually complete and investigation and prove fraud.

Agency Response: The commenter's request is outside the scope of the Chapter 10 rules. Insurance Code §1305.106 states that Labor Code §408.027 applies to a carrier's payment, reduction, denial, or determination to audit a claim for services provided through a workers' compensation health care network. Labor Code §408.027(g) authorizes the commissioner of workers' compensation to adopt rules as necessary to implement Labor Code §408.027 and §408.0271.

Fraud: A commenter is concerned about fraud in the context of designated doctor issues and thinks that there should be some criteria so that injured workers cannot just say they are unhappy with the treatment plan the network has given them and just go to a designated doctor.

Agency Response: The Labor Code, at §408.0041, gives injured workers the opportunity to seek an opinion from a designated doctor for certain issues. The department declines at this time to place limits on this allowance in the statute, but will monitor this issue in the context of concerns regarding fraud.

§10.1: The commenter recommends the adoption of language to more clearly define a pharmacy's role within the Act. The commenter believes that any properly licensed pharmacy that wants to participate in the network should be permitted to do so and that there should be no restrictions on an injured employee's ability to

select a pharmacy. The commenter requests the addition of language specifically setting forth this ability. Another commenter recommends the addition of language to clarify that pharmacy and pharmacy services may not be delivered through a workers' compensation network to preserve choice among pharmacy providers by injured workers.

Agency Response: The department declines to make the requested changes. Insurance Code §1305.101(c) states that prescription medication or services may not be provided via a workers' compensation network. Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

§10.2: The commenter proposes adding the Labor Code definition for "health care reasonably required" to the list of definitions adopted from Labor Code §401.011 for later use in Subchapter F (related to utilization review and retrospective review) of these rules.

Agency Response: The department declines to make the requested change. The term "utilization review," as used in the statute, has the meaning assigned by Insurance Code Article 21.58A. The term is defined in Article 21.58A by using "medical necessity" rather than the commenter's suggested language.

§10.2: A commenter asks whether the rule excludes non-risk assuming preferred provider organization (PPO) networks from those entities that are able to operate as a certified workers' compensation health care network. If so, the commenter requests that the department provide a definition that distinguishes between a PPO plan and a PPO network. Another commenter recommends that health care providers should be allowed to form workers' compensation networks in Texas as they are allowed to do so in managed care and in other states and therefore requests the specific addition of "groups of health care providers" as a new subsection (5) to §10.1(a).

Agency Response: The language of §10.20(a)(2) (§10.20(2) as adopted), combined with the definition of "person" in §10.2, allows a non-risk assuming PPO network to be certified and operate as a workers' compensation health care network. Any person, including a PPO network formed by providers or another entity, that is performing the acts described in §10.20(a)(2) (§10.20(2) as adopted) is required to obtain certification from the department. As a result, the requested definitions of "groups of health care providers," PPO plans and PPO networks are unnecessary.

§10.2: A commenter requests that the department create a special term and definition for the four types of entities that can contract with or establish networks for use throughout Chapter 10 wherever applicable when the term "insurance carrier" or "carrier" is used. The commenter then recommends modifying §10.2(18)(C) by deleting the reference to an insurance carrier and inserting the defined term for the four entities.

Agency Response: The department declines to make the requested change. "Insurance carrier" is defined in §10.2(b)(12) by reference to Labor Code §401.011(27). Labor Code §401.011(27) defines "insurance carrier" as: (A) an insurance company; (B) a certified self-insurer for workers' compensation insurance; (C) a certified self-insurance group under Chapter 407A; or (D) a governmental entity that self-insures, either individually or collectively. Therefore, the references to "insurance carrier" or "carrier" throughout the rule include those four types of entities that can contract with or establish networks.

§10.2: A commenter requests that the department define medical necessity according to the American Medical Association guidelines.

Agency Response: The department declines to revise the proposed rule to incorporate the requested change. Such revisions would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The department will monitor to determine if future revisions to the rule are necessary.

§10.2(a): The commenter recommends deleting the phrase "unless the context clearly indicates otherwise" from the first sentence in §10.2(a) because it allows for the selective use or interpretation of each definition.

Agency Response: The language is statutory and allows for sufficient flexibility where required while still setting forth a specific meaning for each defined term. The department declines to make the change.

§10.2(a): Commenters requested that the department define the terms "medically necessary" and "medical necessity" in order to avoid confusion regarding the interplay between appropriate, necessary or reasonably required services. Other commenters state that there will be no consistency in determinations because the definitions of "adverse determination," "fee dispute" and "independent review" reference "medically necessary or appropriate," without providing a specific definition of the phrase "medically necessary or appropriate." Another commenter requests that the entities that make the determination be specifically identified in the rule because without definition it is unclear whether the health care providers decide which injuries should and should not be treated and to what extent; or, should a reviewer make that decision post-injury having never seen the patient and not knowing how complete the documents or file provided may be?

Agency Response: The department declines to add a definition for these terms without first affording all interested parties an opportunity for comment. As to the concern regarding the entities that make particular determinations referenced by the commenter, the rule and the statute identify the appropriate entities without the need for additional definitions. The available levels of review of the determination that are available are likewise identified in the rule. In general terms, both the statute and the rule reference Insurance Code Article 21.58A, which provides that a carrier or licensed utilization review agent is charged with determinations of medical necessity and issuing adverse determinations.

§10.2(a): Commenters recommend the addition of language to define "medical treatment guidelines," "nationally recognized," "outcome focused," and "scientifically valid."

Agency Response: The department believes that the terms are generally understood and do not require definition. The department declines to make the suggested change.

§10.2(a): A commenter states that the definition of "adverse determination" is inconsistent with the definition contained within Insurance Code §843.002(1) and should be made consistent with the HMO Act. The commenter believes that the provisions in the HMO Act and the Texas Workers' Compensation Act should be consistent to the extent possible so that the workers' compensation system will mirror the commercial products in the market.

Agency Response: Section 10.2(a)(1) reflects the language of the statute at Insurance Code §1305.004(a)(1). The department declines to make the change. §10.2(a)(4): A commenter recommends adding language that specifically references allowing a person's agent or assignee to qualify as a complainant under the definition.

Agency Response: The definition of "complainant" mirrors the statutory definition in Insurance Code §1305.004(a)(4). The definition does not preclude an agent or assignee from filing a complaint.

§10.2(a)(6): A commenter would like to see a further move toward the standardization of credentialing by all parties with procedures being subject to open records and specific time limitations for notification.

Agency Response: The definition of "credentialing" mirrors the statutory definition in Insurance Code §1305.004(a)(6), which does not include a time limitation for notification or address whether the records are subject to disclosure under the Public Information Act. The department handles open records requests on a case-by-case basis in accordance with the Public Information Act, but will not generally possess the credentialing records of each provider that has contracted with a network.

§10.2(a)(7): A commenter requests that the definition of "emergency" needs elaboration for circumstances in which an injured worker goes to an emergency room on weekend or after work hours. The commenter feels that there should be more clarity as to who determines if the emergency room visit is defined as an emergency instead of a means to receive care outside the network.

Agency Response: The rule defines "emergency" as "...either a medical or mental health emergency." The rule does include definitions for medical emergency and mental health emergency to provide the additional clarity the commenter seeks.

§10.2(a)(14): A commenter commends the department for including a broad definition of the term "live." Another commenter requests that the definition of "live" specify whether the term applies to the pre-injury or post-injury location.

Agency Response: The department appreciates the supportive comment. The definition of "live" applies before or after an injury, but is likely going to be an issue once an injury has occurred, as the definition is an integral part of determining whether an injured employee is required to seek treatment from network providers.

§10.2(a)(14): Another commenter states that the definition of "live" should address the distance an injured worker can be expected to travel to receive care, noting that the reimbursement threshold that TWCC has used historically was 20 miles.

Agency Response: The access standards are set out in §10.80. Injured employees must be able to obtain care within the required mileages. The 20-mile reimbursement threshold for travel expenses is not a medical benefit and, therefore, is outside the scope of these rules. The commenter may refer to the Division's rule at 28 TAC §134.6, relating to travel expenses incurred by the injured employee, which will continue to apply until amended or repealed.

§10.2(a)(14): A commenter states that the definition of the term "live" should be changed to indicate that if any of the three definitions are met, it shall be deemed that the injured employee lives in the health care network area of service.

Agency Response: The department declines to make the requested change, as the change would result in employees not being allowed to temporarily establish a residence outside the service area when so required due to work or injury. In many circumstances, it would not be reasonable to expect an employee to travel into the service area to receive health care. The definition recognizes this and provides the necessary flexibility for employees who are temporarily outside the service area due to work assignments or recovery from an injury.

§10.2(a)(14): A commenter states that the definition of the term "live" needs clarification to avoid creating a loophole that enables injured employees to avoid receiving their treatment from the healthcare network and to prevent "bad player" doctors who will not be able to participate in networks from encouraging and assisting injured employees with finding a temporary residence for the purpose of receiving necessary assistance with routine daily activities (e.g. out-of-network healthcare).

Agency Response: Although some interested parties may see temporary locations as a potential loophole for fraudulent employees or providers, the absence of a temporary allowance in the rule would operate as an unreasonable restriction on an employee's right to receive health care services for a compensable injury. Additionally, temporary locations where an employee may live aid in the goal of providing necessary care in an effort to return the employee to work in a more efficient and expedient manner. Delaying care may delay the return-to-work date for an injured employee and unnecessarily punishes an employee who is attempting to return to a job that requires temporary assignments to new locations and an employee who is attempting to recover from an injury in order to return to work. By including a mechanism through which a carrier may contest an employee's assertion that the employee lives outside the network, the adopted rule strikes a balance between avoiding potential fraud and delivering necessary care to an employee who is forced to temporarily relocate.

§10.2(a)(14): A commenter requests that the department change the definition of "live" at §10.2(a)(14)(A) to include the terms "fixed" and "permanent" to describe the principal place of residence. The commenter requests that the phrase "temporary residence necessitated by employment" be replaced by "temporary residence required by the employer." The commenter also requests that the term "activities of daily living" replace the term "routine daily activities."

Agency Response: The addition of "fixed, permanent and" before "principal residence for legal purposes" could unfairly impact some workers with seasonal jobs, or employed students who attend school out of town, for example. Further, the proposed change of temporary residence "necessitated by employment" to a temporary residence "required by the employer" could unfairly burden an individual who no longer works for the employer at the time of injury but travels due to new employment or self employment. The department recognizes that an injured employee may need to change residence to procure assistance with the activities listed in the definition of "routine daily activities." Because the definition is reasonably clear, the department declines to change the language in the definition of "live."

§10.2(a)(14): Several commenters request that, in order to prevent fraud, the definition of "live" be revised by adding language to exclude any residence acquired post-injury solely for the purpose of avoiding inclusion in the network. Another commenter requests that, to address fraud, the definition of "live" be limited to the employee's principal place of residence, legal domicile, or

place of employment and to employees who may move outside the network to avoid network requirements.

Agency Response: The department declines to add the suggested new language because it may be impossible for the network, the carrier or the department to know with certainty or to prove that an employee's motive in moving to a new residence was to avoid receiving health care from network providers and not for other valid reasons. While a carrier may be able to establish that an injured employee had the opportunity to choose a residence inside the network's service area, that does not establish that the employee's sole motivation was to avoid receiving care from network providers. The adopted rule includes the flexibility for an employee to move outside the service area for a variety of reasons. The commenters' request to place strict limits on an employee's right to move outside the network will eliminate the flexibility that may be necessary, for example, when injured employees require continued care after an injury and choose to temporarily live with a family member who lives outside the service area. The department declines to restrict an employee's ability to relocate or to establish a presumption that any post-injury change in residence is invalid or fraudulent.

§10.2(a)(14): A commenter feels that the presumption of the employee's residence found in §10.61(b) and the definition of "live" in §10.2(a)(14) have a potential conflict if the employee's residence on file with the employer or insurance carrier does not meet any of the three prongs of the test set forth in the definition of "live." The commenter notes that there is no mechanism establishing the party that chooses which prong of the test must be met in any given circumstance. The commenter also points out that there is no definition or standard for a fraudulent or material misrepresentation in this rule.

Agency Response: The department disagrees that a conflict exists between §10.61(b) and §10.2(a)(14). The presumption in §10.61(b) is that any address the employee has filed with the employer is where he or she lives. The adopted §10.2(a)(14) includes language consistent with §10.61(b) that includes the address on file with the employer as the principal residence for legal purposes. The presumed address is either inside or outside of the service area, and the employer must deliver notice of network requirements accordingly. If the employee later chooses to assert that he or she lives outside the service area based on the definition in §10.2(a)(14), he or she may do so by following the procedure outlined in the rule. If the employer or carrier determines at a later date that the employee does not live at the presumed address based on the definition in §10.2(a)(14), the employer or carrier must deliver notice of network requirements accordingly.

§10.2(a)(15): Several commenters request that the definition of "medical emergency" include either a "reasonable person" or "prudent layperson" standard. Some commenters point out that the "prudent layperson" standard for emergency care is used in the HMO and PPO statutes.

Agency Response: The definition included in the rule mirrors the statutory language at Insurance Code §1305.004(13) and (15). §10.2(a)(16): A commenter believes the definition of medical records of an injured employee should also include records relating to pre-existing medical conditions that may be relevant to treatment of the injury and not be confined only to the "injury."

Agency Response: The definition of "medical records" in the statute does not include records that may be relevant to a pre-existing condition that may or may not be related to the injury. The department declines to extend the definition beyond the statute.

§10.2(a)(18): A commenter expresses confusion regarding the status of a non-risk assuming PPO network and whether it meets the definition of "network" if it is contracting with providers for delivery of services to injured employees, as it is not technically providing health care services and does not appear to meet the definition.

Agency Response: Because only licensed providers can actually provide health care services to injured employees, it is not the intent of the definition to exclude entities that contract with licensed providers in order to provide health care services. Because any "person" may form and operate as a workers' compensation health care network, it is sufficiently clear that the network itself does not have to actually provide the health care services. Insurance Code §1305.101(a) states that, except for emergencies and out-of-network referrals, a network shall provide or arrange for health care services only through providers or provider groups that are under contract with or are employed by the network. For clarification, the department has changed §10.2(a)(18) by adding "or arrange for" to the definition of "network" or "workers' compensation health care network."

§10.2(a)(20): A commenter states that the requirement for board certification for an "occupational medicine specialist" will limit the number of participating physicians because there are many qualified physicians who practice occupational medicine but are not board certified.

Agency Response: Insurance Code §1305.301(c) requires that a network have a medical director who is an occupational medicine specialist or employ or contract with an occupational medicine specialist. This requirement does not apply to all participating physicians.

§10.2(a)(22): A commenter states that there are numerous grounds under the statute and rules under which carriers can deny claims (eligibility, employees' failure to comply with various network requirements, medical necessity, and compensability), many of which are beyond the control of the provider. Therefore, the commenter requests that the department should create processes by which providers may ascertain the carrier's liability prior to rendering services. The commenter asserts that providers should have the right to preauthorize any proposed services to avoid denials based on medical necessity and should also be entitled to verify an employee's eligibility and treating doctor status. Another commenter asserts that, to the extent a provider verifies an employee's eligibility and treating doctor status and preauthorizes the services, the final rules should provide that the carrier is liable for the services provided and may not deny liability on any basis except compensability.

Agency Response: The statute, at Insurance Code §1305.351(c), allows a network to determine which services require preauthorization. Further, the statute specifically contemplates the availability of a retrospective review process throughout Subchapter H of Chapter 1305. The department thus declines to require networks to predetermine any and all potential services. Once a network has preauthorized a service, however, a network may not deny payment due to medical necessity.

§10.2(a)(22): A commenter requests that the definition of "preauthorization" be revised to state that the term only relates to an approval with regard to the medical necessity of the proposed treatment in order to clarify that preauthorization does

not relate to issues of compensability of other matters. This clarification is necessary to facilitate understanding and minimize unnecessary disputes among stakeholders over the intent of these regulations. Other commenters request that the definition be amended to include a review of whether the services were related to the injury since insurers are not required to pay for services that are not related to a compensable injury.

Agency Response: Preauthorization of a proposed service is a determination that the service is medically necessary. The statute reinforces this by providing that a denial of a request for preauthorization is an adverse determination that triggers applicable utilization review appeal requirements. Furthermore, the statute does not allow a network to deny a claim based on medical necessity if the network preauthorized the service.

§10.2(a)(25): A commenter requests that the term "medical necessity" in the definition of "retrospective review" be replaced with the term "health care reasonably required."

Agency Response: The definition in the adopted rule is consistent with the statutory definition, and the department declines to make the requested change.

§10.2(a)(25): A commenter recommends that the definition of "retrospective review" should be enhanced to include a standard contained within Insurance Code Article 21.58A, §4(i), which would require such reviews to be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or guidelines. Other commenters request that the definition of retrospective review include a reference to the "relatedness" as well as the reasonableness of health care.

Agency Response: The department declines to make the change. The definition in the rule mirrors the definition provided in the statute. Furthermore, Insurance Code §1305.352 provides that retrospective review determinations shall be based on written and periodically updated screening criteria that include appropriate involvement from doctors, including practicing physicians. This standard is not included in the definition but nevertheless does apply to the retrospective review process.

§10.2(a)(26): Commenters request that "working" be added to the list of items in the definition of "routine daily activities."

Agency Response: The department declines to make the requested change. Employees are required to participate in the network only if they live in the network's service area. Adding "working" to this definition would nullify that limitation.

§10.2(a)(27): A commenter requests that the definition of rural area accommodate the many cities in Texas that have populations of 75,000 - 100,000 but should still be considered rural. Another commenter requests that the department clarify whether county population should be determined based upon the 2000 census or a more current estimate or periodically adopt a list of counties meeting the rural population threshold.

Agency Response: The rule incorporates the definition from Insurance Code §1305.004(22) and does not designate any other area as rural. The department will monitor whether areas other than the areas defined by statute should be included within the definition of "rural" for future rulemaking if necessary. The department clarifies that the most recent US census should be used to determine county population.

§10.2(a)(29): A commenter believes that the definition of "service area" should specify a distance an injured worker can be expected to travel to receive care.

Agency Response: The term "service area" refers to the counties that a network may serve and does not relate to the distance a person who lives in the service area must travel to receive care from a network provider. The commenter's concern is addressed in the access standards provision of the statute at Insurance Code §1305.302.

§10.2(a)(32): A commenter requests that the definition of "utilization review" be changed to: "a system for prospective or concurrent review of the health care reasonably required to treat an employee's injury."

Agency Response: The definition in the rule is identical to the statutory definition, which references the definition in Insurance Code Article 21.58A. The department declines to make the requested change.

§10.2(b)(6): A commenter requests that the department include the definition of "evidence-based medicine" and the other definitions referred to in Labor Code §401.011 in the rule so that there is evidence of clear and unambiguous meaning and to ensure continuity between networks in regard to guidelines.

Agency Response: The reference to the Labor Code definitions provides adequate clarity to all interested parties, as the definitions in the Labor Code are clear and understandable. In incorporating the definitions by reference, the department has attempted to avoid unnecessary repetition of the statutory language. The department, however, has included statutory language when needed for clarity. The Labor Code definitions are appropriate for reference and do not add ambiguity to the rules.

§10.20: A commenter states that the statute and rules specifically prohibit a person from operating or performing any acts of a workers' compensation healthcare network unless certain specified conditions are met, yet there is no enforcement mechanism included in the proposed rule. The commenter is concerned that the rule does not indicate what action will be taken against the carriers that continue to operate informal voluntary networks without proper certification and believes that this issue will be particularly important in "non-network" areas of the state.

Agency Response: The department is currently considering its enforcement options. To the extent there is any limit to the department's ability to enforce Insurance Code Chapter 1305, other means, including referral to the Office of the Attorney General, may be considered.

§10.20: A commenter asks whether the carrier, employer and PPO can apply jointly for certification and if this is permissible, whether the network can become certified and then add the carrier and employer.

Agency Response: The certification requirements in Insurance Code Chapter 1305 do not contemplate this type of certification. If a carrier contracts with a single network in one service area, the network must be certified. However, if a carrier contracts with more than one network to serve a single service area, the carrier itself must be certified regardless of whether the networks are individually certified.

§10.20: A commenter states that based on §10.20, if a non-risk assuming PPO network is not allowed to file for certification as a workers' compensation network, it also is prohibited from: (1) operating or performing any act of a workers' compensation net-

work, such as advertising that it provides a workers' compensation network (albeit uncertified); and/or (2) contracting with providers and/or clients for referral of enrollees for workers' compensation health care services to workers' compensation certified providers.

Agency Response: Any person who meets the requirements of the statute and rules may apply for and obtain certification as a workers' compensation health care network. The definition of "person" in the rules at §10.2(a)(21) is broad enough to allow a non-risk assuming PPO network to apply for and obtain certification. If an entity, including a non-risk assuming preferred provider network, seeks to operate or perform any act of a workers' compensation health care network in this state, including those mentioned by the commenter, it must be certified.

§10.20: A commenter asks if a PPO that does not operate as a workers' compensation health care network as defined in HB 7 may grant access to contracted rates for services rendered under the workers' compensation statutes. The commenter asks if a PPO which only provides access to contracted rates for participating providers and payors is in conflict with the provisions of HB 7.

Agency Response: The commenter appears to be addressing voluntary networks, which are not allowed under HB 7. The specific statutory requirement that any person operating or performing the acts of a network be certified by the department, coupled with the broad definition of "network" in both the Texas Labor Code and Texas Insurance Code and the repeal of §408.0223, Texas Labor Code, support the conclusion that voluntary or "informal" networks must be certified to continue providing or arranging for medical care to injured employees.

§10.20: A commenter states that many self-insured employers contract with third party administrators (TPAs) to perform many of the managerial administrative functions. Some TPAs or insurance companies offer administrative services to their self-insured clients. The commenter asks that the rules explicitly recognize third party administrators and states that third party administrators are eligible to apply for certification as workers' compensation provider networks.

Agency Response: The department declines to make a change to the rule because any third party administrator who is a person, as defined by Insurance Code §1305.004(a)(18) and §10.2(a)(21), is eligible to apply for certification as a workers' compensation network.

§10.20: A commenter believes that the exception to certification for prescription services should be expanded to apply to the provision of durable medical equipment and recommends the addition of new subsection (c) that would allow providers, carriers, or employers to contractually assign or outsource claims processing, billing, collections, or fulfillment of durable medical equipment benefits or services deemed medically necessary and appropriate.

Agency Response: The department declines to make the requested change, as Insurance Code Chapter 1305 does not exempt any entity from the requirements for certification set forth in Insurance Code §1305.051(b). The department notes that durable medical equipment (DME) is not a pharmacy service. The Labor Code §401.011(19) describes pharmaceutical services to include a prescription drug, medicine, or other remedy. Therefore, despite the prohibition set forth in Insurance Code §1305.101(c), pharmacies may contract with certified networks to provide DME to injured employees. In addition, the rule does not prevent providers, carriers, or employers from outsourcing the other functions mentioned by the commenter, as those would occur in the non-network setting.

§10.20(a)(1): A commenter seeks clarification of the meaning of the phrase "any act of a workers' compensation health care network." Another commenter notes that the prohibition against an entity "performing any act of a workers' compensation health care network" using certain terms, including "workers' compensation," is problematic because what constitutes an "act" of a network is not defined. The commenter states that many activities performed by networks (e.g., utilization review) are explicitly permitted for other entities under the Labor Code.

Agency Response: Section 10.20(a)(1) (§10.20(1) as adopted) is consistent with Insurance Code §1305.051(b), which states that a person may not perform "any act of a workers' compensation network . . . ." Insurance Code §1305.004(16) and §10.2(a)(18) of the rule as adopted define a workers' compensation health care network as an organization formed as a health care provider network to provide or arrange to provide health care services to injured employees. While the department notes that utilization review and preauthorization services may be provided by the network, these activities do not constitute the acts of a workers' compensation health care network. Any certified utilization review agent may perform these services.

§10.20(a)(2): Some commenters believe that the requirement for certification for any person who contracts with more than one person restricts the ability of insurance carriers to enter into contracts not related to certified network issues. For example, some commenters observe, a carrier can enter into contracts for fees that differ from the promulgated fee guidelines, and such contracts do not appear to have been contemplated in HB 7 as constituting a "network," as envisioned in HB 7. These commenters request that §10.20 be revised to clarify that the definition of "network" does not include such fee arrangements.

Agency Response: The department disagrees that the certification requirements restrict a carriers' ability to enter into contracts not related to certified networks because the rule addresses who must hold the certification if the carrier contracts with multiple entities to provide or arrange to provide health care services in a service area. Any person or insurance carrier who provides or arranges to provide health care services to injured employees in a particular service area by contracting with more than one certified network, provider group, or other entities, or combinations thereof, must hold a certificate as a workers' compensation health care network. The department recognizes, however, that Labor Code §413.011(d) allows an insurance carrier to directly contract with a health care provider outside of a certified network for fees either above or below the Division's medical fee guideline.

§10.20(a)(2): A commenter requests clarification on who can establish or contract with a network. The commenter states that the provision applies to a "person" defined as: "any natural or artificial person," which would include an insurance carrier, third party administrator, or other managed care entity that provides or arranges for health care services to injured employees. However, the commenter notes that §10.1(b)(2) states that Chapter 10 applies to "...an insurance carrier as defined by Labor Code §401.011 that establishes or contracts with a workers' compensation health care network." Because the definition of an insurance carrier does not include third party administrators or other managed care companies that provide or arrange for health care services, the commenter requests that the section be revised to

include "a third party administrator or other managed care entity."

Agency Response: The department disagrees that the suggested language is necessary because Chapter 10 also applies to any "person who performs a function or service of a workers' compensation health care network . . . including a person who performs a function or service delegated by or through a workers' compensation health care network," which could include a third party administrator. Thus, a third party administrator may apply for and obtain certification as a network.

§10.20(b): A commenter believes the Act contemplates that networks may contract with a pharmacy benefit manager to deliver pharmacy services, and that the Act exempts the pharmacy benefit manager from workers' compensation network certification. The commenter also states that the Act does not prohibit workers' compensation provider networks from offering prescription services. The commenter recommends that the rules be clarified to ensure that pharmacy benefit managers and other entities that workers' compensation networks hire to arrange for workers' compensation pharmacy services are not treated differently than any other entity offering similar services in the commercial market. Thus, the commenter recommends revising the subsection to require that "persons who contract with more than one person to provide or arrange to provide prescription medication services, while not needing to be certified, must still abide by all laws and rules relating to the delivery of pharmacy services and benefits."

Agency Response: The department disagrees that workers' compensation health care networks may contract to provide pharmaceutical services to injured employees. Insurance Code §1305.101(c) states that notwithstanding any other provision of this chapter, prescription medication or services, as defined by Labor Code §401.011(19)(E) may not be delivered through a workers' compensation health care network. Consequently, the department declines to make the suggested change.

§10.20(b): A commenter suggests language to "further clarify the legislative intent of HB 7 to exempt pharmacy" from network certification requirements. Specifically, the commenter requests that language be included in the subsection stating that "subsections (a)(1) and (2) do not apply to the agents or assignees of providers, carriers, or employers in the provision of prescription medications or services." The commenter believes this change would preserve an injured worker's access to pharmaceutical care and provide consistency in the delivery of prescription medications and services.

Agency Response: The department declines to make the requested change as Insurance Code §1305.101(c) does not exempt pharmacies from the certification requirements. Rather, it states that prescription medication or services, as defined by Labor Code §401.011(19)(E) may not be delivered through a workers' compensation health care network. Consistent with the provisions of Insurance Code §1305.101(c), the activities referenced in §10.20 do not include those relating to the provision of prescription medication or services. The department has amended proposed §10.20(a)(2) (§10.20(2) as adopted) to state that the section applies only to those entities that provide network health care services. As a result of the amendment to proposed §10.20(a)(2) (§10.20(2) as adopted), the department has deleted subsection (b) as unnecessary.

§10.21: A commenter recommends adding language to the rule that would make charging a provider an application fee by the network a violation. The commenter reports that newly forming networks are marketing membership to providers, charging fees as high as $3,000 per applicant, and will not be able to apply for certification until January 2006.

Agency Response: The department declines to add the suggested language. The department believes that any change to the rule in response to this comment would be a substantive change to the rule and would not allow all interested stakeholders to comment.

§10.21(a): A commenter requests that multiple affiliated carriers be allowed to submit one application, certifying each member of the group since the affiliated companies are sharing the same systems and resources. Another commenter believes that the proposed non-refundable fee should include a provision indicating that the initial fee covers the application for an entire carrier group (not per "underwriting entity") or entire business entity that may have multiple service models for its clients. The commenter recommends that there be one certification with sub-certified addendums. By allowing sub-applications and certifications, the commenter asserts, the department can reduce redundancy and costs. The commenter recommends that the language in §10.21(a) be revised and provides suggested language to reflect that a single application may include a certification that encompasses multiple configuration service offerings where each configuration can be offered singularly or collectively and that carrier groups may file one application for all of their carriers as long as the carriers are specifically named and any components of the application that are different are clearly delineated.

Agency Response: The department declines to make the requested changes because changes are unnecessary. While Insurance Code Chapter 1305 and the rule do not contemplate that a group of carriers may, as a carrier group, receive a single network certification, the adopted rule would allow one carrier in the group to be designated as the network and apply for certification. The other carriers in the group may contract to use that network. However, if a carrier contracts with more than one network or provider group to provide health care services in one service area, the carrier must file for certification as a network. The carrier may submit one application with multiple attachments relating to the multiple configuration service offerings.

§10.21(a): A commenter recommends that this section be amended as in §10.81(c)(1) to reflect national certifications by NCAQ, JCAHO, URAC, and AAAHC. The commenter feels that the certification requirement provides greater credibility for the networks and providers as well as setting standards needed to reestablish confidence in the Workers' Compensation System.

Agency Response: The department declines to require applicants for network certification to have obtained any national certification prior to submission of an application, as the Insurance Code Chapter 1305 does not require such certifications.

§10.21(a): A number of commenters believe that the $5,000 fee for certification is too high. One commenter states that the fee may be particularly high when considering that a network may have to apply several times if different insurers or partners will provide specific services under the statute. Other commenters state that the proposed fee is excessive when compared to other states' network certification processes. These commenters note that some of the states do not charge applicants at all (e.g., California) and other states' fees range from $500 - $3,000. A commenter believes that such a fee will deter companies considering certification and is not in the best interests of this initiative, as it

will result in a decrease in the data that will be available showing the impact of the networks.

Agency Response: The certification fee is a one-time fee, and no additional fees are charged for subsequent filings or for possible onsite examinations, regardless of the number of examinations the department may conduct. The department believes that the fee amount is reasonable. It is based upon the average cost of $4,249 per examination charged to HMOs over the past five years. Additionally, Insurance Code §1305.251 and §1305.252 provide for examinations of networks and providers or third parties if the commissioner deems such examinations necessary. With regard to the concern that a network may be charged multiple certification fees, there is only one certification fee per network regardless of the number of carriers with which the network contracts. Also, while the amount of other states' application fees may be less, the funding mechanism in some states may involve payments from other sources. In addition, the department notes that other states require certification renewals and charge renewal fees. The department also declines to charge different fee amounts based on the complexity of the network or the size of the service area because such a change could require the department to charge additional fees subsequent to certification to cover additional costs in certain instances (for example, if a network significantly increases its service area post-certification). The department believes that the charge of a single, one-time only fee at the time of application is less cumbersome for networks than charging different fees at the time of application and then possible additional fees for subsequent filings.

§10.21: A commenter recommends amending §10.21 by adding new subsection (d) to state "By submission of the application, the applicant is confirming that a contractual agreement in which the providers have specifically agreed to provide treatment for injured workers' in the workers' compensation system exists between the applicant and the providers that are listed in the application in accordance with Section §10.22(11)" in order to clarify that providers will not be forced into participating in the new system without ever having affirmatively agreed to do so.

Agency Response: The department disagrees that the new subsection should be added to §10.21. However, the department has made changes to the contracting provisions in §10.42(b) by adding paragraph (14) to require that the provider contract state that the provider specifically agrees to provide treatment for injured employees who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

§10.22: A commenter believes that all information required of an applicant and submitted to the department as a part of the application process should be public information and available under the Open Records Act.

Agency Response: The department will comply with the confidentiality requirements in Insurance Code Chapter 1305 and any requirements in the Public Information Act.

§10.22: A commenter expresses support of §10.22(11)(A) and (B). The commenter recognizes that a small but significant population, approximately 15% of injured indemnity workers, according to the Division of Workers' Compensation's Medical Director, account for 80 - 85% of lost time and medical dollars paid. The commenter believes that this important sub-population of patients should be carefully managed to prevent the development of chronic disability and excessive utilization of medical care. The commenter believes that evidence-based medical guidelines indicate that appropriately structured, high quality interdisciplinary rehabilitation programs are the treatment of choice to prevent or turn around the lives of many workers that get caught in the chronic disability mindset. Many of these workers, the commenter notes, can be rehabilitated if they are able to get timely and appropriate interdisciplinary care.

Agency Response: The department appreciates the supportive comment.

§10.22 and §10.22(3) - (6): Some commenters request that information filed under this section be held by the department as confidential and not subject to disclosure under the Texas Public Information Act. Some of the commenters specifically request that the rule be revised to ensure the confidentiality of the network-provider, third party delegation, network-carrier, and management contracts. A number of commenters note that the contracts include competitive and commercially sensitive information that if disclosed could foster anti-competitive activity in the market and diminish innovation and efficiency.

Agency Response: The department is required to follow the provisions of the Texas Public Information Act, as well as all other applicable laws in order to protect confidentiality interests. Much, if not all, of the information the commenters seek to protect from disclosure is protected pursuant to the provisions of Insurance Code Chapter 1305. Under §§1305.102(k), 1305.152(a), and 1305.154(a), management contracts, network contracts with providers, and network-carrier contracts, are confidential and not subject to disclosure as public information under Government Code Chapter 552.

§10.22(7): This subsection states that network applicants must submit their financial statements prepared in accordance with generally accepted accounting principles. However, many applicants are likely to be workers' compensation carriers, accident and health insurance carriers, and HMOs, all of which are required to use statutory accounting when preparing financial statements for submission to the department. Requiring the same entity to prepare its financial statements using the two different methods would be unduly onerous and costly.

Agency Response: This requirement is consistent with Insurance Code §1305.053(5), which requires a "financial statement . . . that is prepared using generally accepted accounting practices . . ." and §1305.201, which requires that the network "prepare financial statements in accordance with generally accepted accounting standards . . ." The statute and rule address financial statements at the network level which are separate from consolidated financial statements.

§10.22(7): One commenter believes that because it is a non-risk assuming provider network, with all the workers' compensation certified providers already designated in its system for referrals, a financial statement can be provided, but it would not be the statement that an HMO or insurer would be required to submit.

Agency Response: The department disagrees that a network can determine what type of financial statement it may provide. The rule is consistent with the requirements set forth by the legislature in Insurance Code §1305.053(5).

§10.22(7) and §10.25: One commenter believes that the financial statements and other financial information required for certification are burdensome and unnecessary. The commenter notes that workers' compensation health care networks are not risk-bearing entities, and therefore, do not require the level of monitoring reflected in the proposal. Consequently, the com-

menter believes that the requirement that any changes to these statements be filed is particularly onerous.

Agency Response: The rule is consistent with the requirements set forth by the legislature in Insurance Code §1305.053(5).

§10.22(7)(E): Some commenters believe that the requirement to submit a financial statement that includes the sources and uses of all funds is excessive for a service organization which assumes no risk of loss and does not pay medical bills.

Agency Response: The rule is consistent with the statutory requirement that financial statements be prepared using generally accepted accounting principles. Nevertheless, in response to comments, the department has deleted the requirement in §10.22(7)(D) for a statement of equity. As adopted, the rule mirrors the statutory requirements under Insurance Code §1305.053(5).

§10.22(10)(B): A commenter recommends that the goals of the quality improvement program be specifically defined.

Agency Response: Section 10.22(10)(B) requires a description of the quality improvement program as required in §10.81, which indicates that the quality improvement program is "designed to monitor and evaluate objectively and systematically the quality and appropriateness of health care and network services, and to pursue opportunities for improvement." Moreover, §10.81(b)(2)(A) requires a work plan to include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, individuals responsible, and evaluation methodology." Because quality improvement goals are unique to each network, the department declines to define them.

§10.22(10)(E): Some commenters request that the rules specify that any HMO doctor chosen by an employee as a treating doctor must be of a specialty utilized by the network as a treating doctor. One of the commenters believes that permitting treating doctors to come from alternative specialties would create confusion in the administration of a network and compromise the network's ability to adhere to its standards for delivery quality care.

Agency Response: The department disagrees that the requested change is necessary. Insurance Code §1305.105(b) requires the HMO provider to comply with the terms of the contract and Chapter 1305, Subchapter C. Insurance Code, §1305.103(a), states that a network shall determine the specialty of the treating doctor. Additionally, §10.42(b)(12) as adopted requires that the provider contract address whether the contracting provider is of a designated specialty to be a treating doctor, and if so requires that additional responsibilities of treating doctors be included in the contract.

§10.22(10)(E): A commenter believes that the plan, not the non-risk assuming network, should provide the criteria and procedures for employees to select or change the treating doctor.

Agency Response: The department disagrees. Consistent with the requirements of Insurance Code §1305.104, §10.22(10)(E) requires networks to have procedures to allow the employee to select and change the treating doctor and must provide information regarding that process with the application.

§10.22(10)(E): One commenter is concerned that the provision related to the submission of criteria for the employee to elect to receive treatment from his/her HMO doctor fails to require that the employee make the election prior to the injury. As the network has an obligation to confirm that the HMO doctor will comply with network and applicable statutory and regulatory requirements, the commenter believes this requirement could delay treatment and frustrate the employee. The commenter requests that the rules require an employee to select his or her HMO primary care physician as the network treating doctor prior to an injury.

Agency Response: Section 10.22(10)(E) specifically refers to procedures for employees to select as the employee's treating doctor a doctor who the employee selected, prior to the injury, as the HMO primary care physician or provider. This is consistent with the provisions of Insurance Code §1305.105(a) which allows an injured employee to select as a treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care physician or provider under Insurance Code Chapter 843. Consistent with the statute, the rule does not require the employee to make a selection of the HMO treating doctor as his or her treating doctor for purposes of the workers' compensation network prior to the injury.

§10.22(10)(E): A commenter recommends that the option be broadened and extended to doctors who are not members of an HMO, and to other providers, including physical therapists, with whom an employee has a previous history, so long as those providers meet network qualifications, agree to adhere to all applicable network policies and procedures, and to accept fees that would be paid to in-network providers or out-of-network providers, whichever is less. The commenter believes this would not violate the legislature's clear admonition to avoid "any willing provider" status for provider inclusion in networks, but rather would ensure accessibility for injured Texans to providers who have previously provided them sufficiently good healthcare service to warrant their pre-injury selection.

Agency Response: The department declines to expand §10.22(10)(E) to providers who are not members of an HMO. This would be inconsistent with Insurance Code §1305.105(a), which is specifically limited to treatment by a primary care physician or provider under Insurance Code Chapter 843. However, in accordance with Insurance Code §1305.105(d), the department will monitor this issue as it evaluates network adequacy and will offer recommendations to the 80th Legislature regarding whether to make statutory changes to allow treatment by non-network providers through a preferred provider benefit plan, as defined by Chapter 1301. The statutory mandate is Insurance Code §1305.105(d).

§10.22(11): A commenter recommends that the reference to §§1305.301 - 1305.304 of the Insurance Code be deleted. The commenter believes that medical directors and review doctors should be required to have a valid license to practice in the state of Texas, and, therefore, be subject to review and disciplinary action consistent with Texas statutes.

Agency Response: The department declines to make the requested change as the references are to the Insurance Code provisions relating to network organization, accessibility and availability requirements, quality of care requirements, and guidelines and protocols that are the basis for these rules. Insurance Code §1305.301(c) requires that the medical director be licensed in the United States. It does not require that the medical director be licensed in Texas.

§10.22(11): One commenter asks for clarification concerning the access, availability and adequacy standards mentioned in the paragraph. The commenter also references a provision in a New Jersey regulation that allows PPOs that are not plans to opt out

of the state's workers' compensation network requirements. The commenter states that a network does not necessarily arrange for the provision of the carrier's entire network, and does not maintain adequacy, availability and accessibility standards, but does provide reports for the carrier/client, showing the extent to which the network meets the carrier's standards.

Agency Response: With regard to the comment concerning adequacy and availability standards, the department refers the commenter to the access and availability standards set forth in Insurance Code §1305.302 and §10.80. With regard to the comment concerning New Jersey's opt-out provisions, it is unclear if the commenter is requesting that the rule include a similar opt-out provision for certain networks. If so, the department declines to include such a provision because Insurance Code Chapter 1305 does not include it. A network that is performing any act of a workers' compensation health care network in this state must obtain a certificate and must meet the requirements of §10.22, including paragraph (11).

§10.22(11): A commenter encourages the department to restore the language in the draft rule that indicated the type of providers that were to be part of the network provider panel. The commenter believes that much of the treatment for workers' compensation injuries requires the use of treatment modalities provided by durable medical equipment providers and suppliers and that the effective use of such modalities can often reduce costs and help a worker return to work more quickly. Therefore, the commenter suggests that contracts with durable medical equipment and other ancillary service providers also be required for network qualification.

Agency Response: The department declines to make the requested change because the composition of the provider panel is dictated by the requirement to provide comprehensive, medically necessary services to treat a compensable injury. If a treatment or service is determined to be medically necessary, it must be provided. Additionally, if the medically necessary treatment or service is of a nature that requires a particular type of provider or specialist to furnish the treatment, service or supply, including durable medical equipment and other ancillary service providers, the network must arrange for such specialist or provider, or authorize an out-of-network referral.

§10.22(11): A commenter believes that the phrase "adequacy of the network to provide comprehensive health care services sufficient to serve. . . ." needs clarification. The commenter states that the adequacy definition based on mileage is insufficient to address physical therapy services because "adequacy" for a recurring service such as physical therapy is much different than, for example, adequacy for a neurosurgery specialty. According to the commenter, because physical therapy care is routinely provided two or three times per week for two weeks or more, it would be unreasonable, and frequently counter-productive, to require a physical therapy patient, especially a post-surgical patient, to drive up to 75 rural miles each way, or 30 miles through city traffic to keep these appointments.

Agency Response: The department declines to include any additional adequacy standards for the provision of physical therapy services because the adequacy provisions in the rule mirror Insurance Code §1305.302(g), which does not include distinct adequacy requirements for the provision of those services. However, nothing in the rule prohibits a network from providing medically necessary physical therapy through a home health care agency at the home of a post-surgical patient or contracting with physical therapy providers within a shorter distance.

§10.22(11)(A): A commenter requests that the terms "treating doctor," "sufficient number," and "medical specialty" within this section be defined. The commenter also asks that the phrase "all health care services can reasonably be expected to be required to treat injured employees in a timely, effective and convenient manner" be clarified.

Agency Response: The department disagrees that these terms and phrases require definition or further clarification. Section 10.2(b)(13), by reference to Labor Code §401.011, defines "treating doctor" as the doctor primarily responsible for the employee's health care for an injury. Although the term "sufficient number" has a commonly understood meaning, §10.22(11)(A) indicates that a sufficient number is that number necessary to provide services in a "timely, effective, and convenient manner" and §10.80(b)(2) indicates that a sufficient number is that number needed to "ensure choice, access, and quantity of care to injured employees." The term "specialty" is a commonly understood term that refers to a physician or other provider who has received specialized training and education in a health care discipline. Whether a network satisfies the requirement that all health care services can reasonably be expected to be required to treat injured employees in a timely, effective and convenient manner will be determined on a case-by-case basis and is, therefore, not subject to definition.

§10.22(11)(A) and (D): A commenter states that information concerning network providers' hospital affiliations and which doctors are authorized to certify maximum medical improvement changes regularly and is not meaningful in the evaluation of a network application. The commenter recommends deletion of this requirement. The commenter recommends requiring the network to confirm that it provides adequate access to hospitals and to maximum medical improvement certifications.

Agency Response: The information required in these provisions is necessary for the department to determine the adequacy of a proposed network. Because the commenter's proposed change would leave the determination of network adequacy up to the applicant, the department declines to make the requested change.

§10.22(11)(D): One commenter indicates an understanding that the network configuration must include information regarding which doctors are certified to perform maximum medical improvement and impairment rating services, but states that the information is not readily available to a network entity. The commenter believes that it would be more appropriate for a utilization review entity and/or carriers who make indemnity and return-to-work determinations to provide such information. Therefore, the commenter recommends that the obligation to report such information be delegated to the utilization review entity.

Agency Response: The department declines to require that the utilization review agent be obligated to report which doctors are certified to perform maximum medical improvement and impairment rating services. The department disagrees with the assertion that this information is not readily available to the network. The network is in the best position to obtain the information because the network can and should request it from providers when they apply to join the network. Additionally, the information is available through the Division of Workers' Compensation.

§10.22(11)(E): A commenter states that the proposed rules do not specifically address access to certain therapies, such as those for chronic pain. The commenter notes that HB 7 requires the Division of Workers' Compensation to "examine whether

injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices" and requires the Division to investigate whether any access barriers exist. The commenter asks that the rules be amended to include this directive from HB 7 so that networks and insurance carriers understand their obligations. The commenter states that given the limited number of providers that perform chronic pain therapies and that specialize in spine surgery, it is important to ensure access to providers qualified and willing to provide the same. The commenter requests that the department add a new subparagraph (E) to require information indicating which doctors are qualified and willing to provide spinal surgery, and which doctors are qualified and willing to provide chronic pain therapies, including the implantation of neurostimulators and intrathecal drug pumps.

Agency Response: The department declines to make the requested change. Workers' compensation health care networks are required to provide comprehensive, medically necessary care to treat a compensable injury. If a treatment or service, including spinal surgery and the implantation of a neurostimulator or intrathecal drug pump, is determined to be medically necessary, it must be provided. Therefore, the department expects that networks will ensure that they have contracts with the providers needed to perform these services. Additionally, the department will be able to monitor this issue through the complaint process to make sure that medically necessary services are available.

§10.22(13): A commenter believes that the required submission of a business plan and two years of pro forma financial projections is excessive and unreasonable, and recommends that the requirement be deleted. Other commenters believe that this type of business plan would not be applicable to a network that does not bear risk. Other commenters are concerned that the requirement seems to go beyond what is necessary and certainly beyond the department's earlier statement that financial requirements would be minimal.

Agency Response: The department routinely obtains business plans for a wide range of different regulatory functions. Moreover, the department believes that prudently run business organizations will typically already have business plans and disagrees that the requirement is onerous. Conversely, the lack of an articulated business plan exacerbates the risk of an entity's failure due to general business risks, economic factors, etc. The requirement relates to a description of the applicant's plans and intended operations so that the department can more fully understand the applicant's profile and operational objectives. While the department does not agree that the proposed requirement is onerous, a change has been made in response to the public comments. The requirement for pro forma financial projections has been deleted and replaced with a requirement for projections related to operations and profitability.

§10.22(14): A commenter believes that, because networks are not risk-bearing entities, the required submission of an authorization permitting the department to confirm reported assets is an inappropriate and unnecessary administrative burden.

Agency Response: The department disagrees that the requirement is inappropriate and burdensome. The requirement relates to a routine audit confirmation process that is widely used across many industries. Moreover, the department routinely and efficiently processes these forms for other entities, typically in a matter of days. Nevertheless, in response to the comments, the department has made a change to exempt licensed, risk bearing entities from the requirement, since their assets are already subject to department examination.

§10.22(15): A commenter is concerned that §10.22(15), which requires an applicant to submit the applicant's plan for provision of care to injured employees who live temporarily outside the service area, is not consistent with Insurance Code §1305.302(j), which states that "[t]he network may not be required to expand services outside the network's service area to accommodate employees who live outside the service area." Because Insurance Code §1305.004(24) defines "service area" as a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area, the commenter asks why a network's application must include a plan for provision of care to out-of-area patients.

Agency Response: The rule requires that the certificate application include the applicant's plan for provision of care to injured employees who live temporarily outside the service area, "if applicable." The department recognizes that networks are not required to expand services outside the network's service area to accommodate employees who live outside the service area. However, if a network chooses to contract with a provider to allow an employee on temporary assignment outside of the service area or receiving necessary assistance with daily activities to receive necessary services, it may do so. If a network does not intend to make services available to employees who are temporarily outside of the service area, the network should so state along with its application.

§10.22(15): A commenter requests clarification of both the terms "temporarily" and "if applicable" as used in this paragraph. The commenter asks how a network applicant will know whether this regulatory component applies to it, given the use of the term, "if applicable." The commenter also asks how many weeks or months may constitute "temporary" and what rights the carrier has if the injured employee ends up exceeding that limit or never returns to live within the service area.

Agency Response: The department declines to prescribe any time frames because "temporarily" is not a permanent change as clearly indicated in the definition of "live" at §10.2(a)(14). Further, this provision only applies if a network chooses to contract to provide out-of-network services for employees.

§10.22(17): A commenter states that, because doctors are not employees of the network, the network should not have to verify that doctors comply with the Labor Code's financial disclosure requirements and requests that the requirement be deleted. As an alternative, the commenter recommends that networks be required to provide information to doctors regarding the financial disclosure requirements. Another commenter also requests that this section be revised to require the network to educate providers regarding their obligations under HB 7. Other commenters stated this requirement is too onerous for a non-risk bearing entity and should be removed.

Agency Response: The department has modified §10.22(17) to require an applicant to provide a plan for obtaining certification of provider filings of financial disclosure with the Division.

§10.22(19): Regarding the applicant's plan for monitoring whether providers have been provided and are following treatment guidelines, return-to-work guidelines, etc., a commenter requests that provisions be made for workers with catastrophic injuries who need therapy and who will most likely not be able to return to work.

Agency Response: Consistent with Insurance Code §1305.304, the rule requires a network to provide as part of the application process the network's plan for monitoring whether providers have been provided with and are following the statutorily required treatment guidelines, return-to-work guidelines, and individual treatment protocols. The requirement does not address the content of the guidelines nor exceptions to guidelines. In addition, workers' compensation health care networks are required to provide comprehensive, medically necessary care to treat any compensable injury, even a catastrophic one. If a treatment or service is determined to be medically necessary, it must be provided.

§10.22(19): A commenter states that the requirement for the network to submit a plan for monitoring adherence to treatment and return-to-work guidelines and treatment protocols is excessive and should not be required. The commenter believes that networks can take appropriate action with regard to any doctors not adhering to their contractual obligations based on complaints filed with the network or other information received through the quality improvement process. This commenter, along with another commenter, recommends that this section be revised to indicate that the network would be required to educate their providers regarding the provider obligations under HB 7.

Agency Response: Insurance Code §1305.304 requires each network to adopt treatment guidelines, return-to-work guidelines and individual treatment protocols. Further, Insurance Code §1305.152(c)(2) requires a statement in the provider contract that the provider agrees to follow the treatment guidelines as applicable to the employee's injury. The department believes that a network should have a process in place to monitor the provider's performance under the contract and the requirements of this provision to simply ensure that the providers are meeting this obligation. Accordingly, the department declines to change this requirement.

§10.22(19): A commenter states that the majority, if not all, of the treatment guidelines on the market are out of date and do not take into consideration the severity of the injury, the healing process of the individual patient, or the job requirements. According to the commenter, although treatment protocols are numerous, most are developed by individual physicians or therapists, and historically, guidelines have been misused to deny services or reduce reimbursement; many times a nonmedical person with little or no knowledge about the patient's injury and rehabilitation program has the authority to approve or deny treatment.

Agency Response: The department believes that the concerns raised by the commenter are addressed by Insurance Code §1305.352, which requires that retrospective review of a health care service be based on written screening criteria, including treatment guidelines, must be established and periodically updated with appropriate involvement from doctors, including actively practicing doctors, and other health care providers. With regard to the commenter's concern about the potential misuse of treatment guidelines, Insurance Code §1305.304 and §10.83(b) specify that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. Because carriers and networks must provide all medically necessary care, a denial based on the medical necessity of the service may be appealed through the utilization review and independent review organization processes. This is true even if services fall outside the treatment guidelines.

§10.22(20): A commenter requests that the terms "evidence-based, scientifically valid, and outcome-focused" that are referred to in §10.22(20) be defined. The commenter believes that treatment guidelines and return-to-work guidelines should be nationally certified as evidence-based, scientifically valid and outcome-focused to assure continuity between networks. The commenter requests that the department specify in the rule acceptable guidelines to be used by networks.

Agency Response: Evidence-based medicine is defined in Labor Code §401.011(18-a). The remainder of these terms are commonly understood terms and should be interpreted as such. Under Insurance Code §1305.304, each network has discrete authority to adopt treatment guidelines and return-to-work guidelines. Consequently, the department declines to specifically identify any particular guidelines in the rule.

§10.22(20): A commenter states that there are no published treatment guidelines that are considered to be "evidence-based, scientifically valid, and outcome-focused" for physical therapy for injured workers. Thus, the commenter states, requiring certification by a network medical director that a network's treatment guidelines meet this standard is meaningless when it comes to physical therapy. The commenter recommends that network medical directors submit their guidelines for appropriate scientific peer review to validate their use and certification. Another commenter recommends that medical directors describe the methodology used to determine the guidelines meet the standard.

Agency Response: The department disagrees that there are no treatment guidelines for physical therapy. The language of §10.22(20) ensures that the network has treatment guidelines in place as required by Insurance Code §1305.304. In addition, Insurance Code §1305.304 and §10.83(b) specify that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. If a treatment or service is determined to be medically necessary, it must be provided.

§10.22(20): A commenter recommends that if the medical director is unable to provide a description of the methodology, or provides one that does not stand up to scientific scrutiny, the network should institute a system of preauthorizing physical therapy services in order to maintain control of the utilization of physical therapy, while still permitting appropriate care that facilitates safe, timely return to work by injured workers.

Agency Response: The department declines to include a requirement that networks provide a description of the methodology for determining whether a treatment guideline meets statutory requirements as part of the application process as it would constitute a substantive change. The department will monitor and evaluate for future rulemaking purposes. While Labor Code §413.014 requires preauthorizations for physical therapy services, that statute does not apply to workers' compensation networks pursuant to Insurance Code §1305.351(c). While Insurance Code Chapter 1305 does not require networks to preauthorize services, if a carrier or network does use a preauthorization process, the requirements of Insurance Code §§1305.351 - 1305.355 and these rules apply. Networks and carriers shall decide which services, if any, will be subject to preauthorization, as set forth in §10.102.

§10.22(20): A commenter suggests that national specialty guidelines that are transparent, peer reviewed, evidence-based, and published by the National Guidelines Clearinghouse should be included as part of the rule.

Agency Response: The networks have the authority under Insurance Code §1305.304 to select treatment guidelines and are not precluded from consideration of national specialty guidelines when making their selection.

§10.22(21): A commenter asks whether the networks should have a medical director on staff. The commenter feels that this point is unclear in the rule and indicates that a medical director on staff is appropriate so that providers could have a direct "peer" to discuss problems they may encounter.

Agency Response: The rule must be read in conjunction with the statute, as all statutory requirements are not repeated in the rule. Insurance Code §1305.301(c) requires each network to have a medical director that is available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network.

§10.22(21): A commenter expressed concern that an occupational medicine specialist is the only designated physician who can serve in the capacity of medical director. Some commenters understand that medical directors are supposed to be occupational medicine physicians, but propose that this be opened to other areas and not to just occupational medicine physicians, and should include doctors that are certified, licensed, board eligible or board certified that can treat occupational medicine-type injuries, but are still considered highly-qualified physicians who have significant experience.

Agency Response: Networks have the options under the rule and Insurance Code §1305.301(c) of appointing a medical director who is an occupational medicine specialist, or if the network's medical director is of a different specialty, the network may employ or contract with an occupational medicine specialist to assist the medical director.

§§10.22, 10.41, and 10.60: A commenter requests that §10.22 (Contents of Application) be amended by adding new subsection "(22) an explanation of their process that will ensure that injured workers already receiving care are guaranteed a reasonable transition period during which they can continue to see their current, non-network physician for a minimum period of 120 days and up to 1 year. Injured workers who qualify for this transitional care provision include those under treatment for: a) an acute condition; b) a serious chronic condition, including but not limited to treatment for chronic intractable pain; c) a terminal illness; d) performance of a surgery or other procedure that was already authorized by the insurer and is scheduled to occur within the following 180 days." The commenter believes that the provision is needed to ensure that the network application delineates how reasonable transition will be allowed. The commenter would also like to add this new subsection to §10.41 (explanation of the process for transitioning injured employees) and §10.60 (explanation of the process to injured workers already receiving care to guarantee a reasonable transition period).

Agency Response: The department declines to make the requested addition as it is inconsistent with Insurance Code §1305.103(c), which states that an employee who lives in the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network must select a treating doctor upon notification by the carrier that health care services are being provided through the network. If the employee does not select a network treating doctor within 14 days after receiving the notice of network requirements, the network will assign the employee a treating doctor.

§10.23: A number of commenters request that if the commissioner does not approve or disapprove an application within 60 days, the application will be deemed approved. One commenter notes that this type of provision is frequently found in department regulations related to other product lines and would be helpful to networks in being able to anticipate timeframes for implementation. Another commenter asks what recourse a network has if there is no response from the commissioner within the allotted time frame.

Agency Response: As provided in §10.23, the department will approve or disapprove an application in accordance with Insurance Code §1305.054(a), which states that "the commissioner shall approve or disapprove the application for certification as a network not later than the 60th day after the completed application is received by the department." The department declines to include a provision "deeming" an application approved because there is no such "deemer" provision in the statute. Unless the applicant requests an extension as permitted under §1305.054(c), the department will approve or disapprove an application not later than the 60th day after the date the department receives the completed application.

§10.24: Some commenters opined that since the network is non-risk bearing, the requirement that the network provide the carrier with an annual financial statement before April 1 of each year should be deleted. According to the commenters, this should be a business decision left to the discretion of the carrier and the network rather than a regulatory one.

Agency Response: The department disagrees with the suggested change. It is the department's interpretation that the statute clearly contemplates that carriers retain ultimate responsibility for compliance with applicable regulatory requirements, including for actions of their contracting networks, and that the carriers will monitor their contracting networks for compliance issues. This interpretation is based on the following statutory provisions enacted in the statute. Insurance Code §1305.154(c)(5) addresses the carriers' ultimate responsibility. Sections 1305.154(c)(6) and (c)(12) address the carriers' oversight of the networks. Section 1305.155(c)(9) provides that a carrier may reassume delegated functions for non-compliance issues at the network level. Further, §1305.155(g)(1) provides the commissioner with discretionary authority to order a carrier to reassume functions from its contracted network if the network is in a hazardous condition. In part, these requirements reflect the need for the carrier to periodically monitor its contracting networks to ensure that the network is not in a hazardous condition, as such condition may precipitate non-compliance issues in other areas.

§10.24: A commenter states that some requirements, both financial and otherwise, appear to contemplate an HMO-type product, but believes it is intended to look more like a PPO model. The commenter points out that the network has no financial risk bearing responsibility. The commenter states that the Division should err on the side of less regulation and do by rule only what is clearly required by statute to implement the new law.

Agency Response: Insurance Code §1305.201(a) requires networks to prepare financial statements in accordance with generally accepted accounting practices (GAAP) standards. Insur-

ance Code §1305.201(b) allows the commissioner to define in rule the manner in which network financial statements should be filed. It is the department's position that the rules are no more prescriptive than necessary.

§10.24(a): A commenter states that in addition to the current requirements in §10.24(a), the section should also require a list of payments made by date, check number, amount paid, provider, injured employee, date claim was received, and date claim was paid, as well as a list of written complaints/appeals and that network's response. The commenter also requests that this information be made available to participating providers.

Agency Response: The department declines to make the suggested change. The provisions of §10.24(a) substantially reflect the statutory requirements of Insurance Code §1305.053(5), for network financial statements, and the commenter's suggestion is inconsistent with such statutory requirements. In addition, the information the commenter requests relates to claim processing rather than the financial statement requirements of a network.

§10.24(b): One commenter expresses strongly that all records relating to networks should be subject to full public disclosure and requests that a provision be added requiring the network to provide its financial statement to "any individual, group, or association requesting them pursuant to the Texas Open Meetings Open Records Act."

Agency Response: The department does not have the authority to add the suggested language as the legislature, rather than the department, determines whether particular information is subject to the Public Information Act. In addition, the Public Information Act applies only to governmental bodies, and not to private entities. Therefore, a network, which is a private entity, would not be subject to its provisions. In responding to an open records request relating to networks, the department, however, is required to comply with the provisions of Insurance Code Chapter 1305 and the Public Information Act.

§10.25: A commenter opines that §10.25 must be narrowed regarding what constitutes a change requiring a filing. The commenter believes the language is so broad that it appears, for example, to require a filing any time a doctor enters or departs the network. The commenter believes this would be unmanageable, both for the network and for the department. As such, the commenter requests that a filing should be required if any one of the following events occur: 1) change in ownership of the network; 2) there are changes in contractual relationships with management services contractors or insurance carriers; 3) there are changes in the governing body; or 4) there are material changes to the description of programs and procedures filed in the initial application. Another commenter states that this filing process would be excessively burdensome to networks and recommends adopting a "greater than 10%" threshold for reporting changes within the network.

Agency Response: The department disagrees. The filing requirements as specified are necessary to enable the department to ensure that all network requirements are being met. The department has reorganized the filing requirements in §10.25 for clarification and has changed subsection (a)(3) to read "material modification of network configuration." The department has also changed subsection (b) to require the network to file with the department any other information besides that in subsection (a) that "amends, supplements or replaces the items required under §10.22...." As a result of this change, a network is not required to receive approval for all changes to network configuration, but rather just to those changes that would affect access to care. The department will monitor this issue through the complaint process.

10.25: One commenter opines that the requirement to file a written request for approval before implementation of a change to network configuration or expansion, elimination or reduction of an existing service area is vague. The commenter asks for clarification as to what would qualify as a change or expansion requiring approval: for example, would a provider terminating be a change requiring approval?

Agency Response: The department has reorganized §10.25 for clarification and changed subsection (a)(3) to require approval for a "material modification of network configuration." As a result of this modification, a network is not required to receive approval for all changes, but rather just those changes that affect access to care. The department will monitor this issue through the complaint process. Expansion, elimination or reduction of an existing service area relates to the counties in which the network is authorized to do business. Because the counties are listed on the certificate for each network and are made available to the public by the department, any modification to the list of counties must be filed with and approved by the department.

§10.25(b)(3) and (4): A commenter states that the requirement for prior approval of modifications of network configuration and service area creates a huge burden when applied to the normal turnover expected among providers in any network. The addition of a single provider on the edge of the service area could expand or contract the service area. This also seems somewhat redundant in that the service area is a part of the configuration.

Agency Response: The department has reorganized §10.25 for clarification and changed subsection (a)(3) to require approval for a "material modification of network configuration." This provision does not require a network to receive approval for all changes, but rather those changes that would affect access to care. The department disagrees that the addition of a provider on the edge of the service area could expand or contract the service area. Because the service area is not tied to location of providers, the addition of a provider on the edge of the service area without a change in the listing of counties in the state in which the network is licensed to do business does not change the boundaries of the service area.

§10.26: One commenter opines that this requirement will be excessively burdensome to networks and recommends adopting a "greater than 10%" threshold for filing modifications to a service area.

Agency Response: The department does not agree that this filing requirement is excessively burdensome. The department declines to adopt any threshold for filing and receiving approval for modifications to the service area because a service area is a listing of counties and ZIP codes where the network is authorized to do business. Any change to a service area requires the commissioner's approval.

§10.26: Several commenters state that while §10.26 requires a greater detail in reporting, the triggering event is essentially the same as in §10.25 (Filing Requirements) and suggest the department consider an exemption regarding prior approval of the addition or deletion of providers in, or adjacent to, the current service area. Commenters posit the exemption to apply to all of the provisions in this section. According to the commenters, an annual requirement to provide updated information should suffice to provide necessary information to the department.

Agency Response: The department declines to make the suggested change. The service area is the geographical area in the state in which the network is licensed to do business. Because the service area is not tied to providers, the addition of a provider on the edge of the service area without a change in the area of counties in the state in which the network is licensed to do business does not change the boundaries of the service area. Any change to the boundaries of a service area requires the commissioner's approval.

§10.26: A commenter states that this section requires the network to file an application and receive approval from the department for all network expansions and reductions in an existing service area, or the addition of a new service area regardless of the significance of the change. The commenter does not understand why a service area addition would require department approval. The commenter states that networks change on a daily basis, thereby requiring the filing of an application which is unduly burdensome. The commenter believes the requirements under this section can be accomplished by other means. The commenters suggest that the department could require the network to file an application when there is material change to the configuration of the network which would have an impact on injured employees' access to network providers. With regard to network additions, the commenter recommends that the department impose a standard on the network that requires the network to inform the department of changes on a semi-annual basis.

Agency Response: The department declines to make the requested change. Nothing in §10.26 requires notification to the department of network expansion in an existing service area. The rule requires submission of a change in service area, i.e., the geographic area in the state in which the network is licensed to do business. Because the service area is not tied to providers, the addition or termination of individual providers without a change in the area of counties in the state in which the network is licensed to do business does not change the boundaries of the service area, and therefore is not a modification of the network's service area. Section 10.27 addresses modifications to network configuration.

§10.26: One commenter states that §10.26 should be amended to read that, consistent with the definition of service area, a modification occurs when there is a change in the geographic area for which the network provides services. The commenter states that changes to the network within a service area that do not adversely impact access to care should not be considered a modification to a service area.

Agency Response: While it is correct that the service area is the geographic area or areas in which the network is licensed to do business, changes to the provider network within the approved service area or areas without changes to the geographic area for which the network provides services do not trigger the requirements of §10.26. Certain changes to the network within the service area, however, could trigger the requirements of §10.27 (relating to Modifications to Network Configuration).

§10.26: A commenter states that networks should not have to wait for approval to expand, eliminate, or reduce an existing service area. According to the commenter, more flexibility is needed to support efforts to ensure that networks remain responsive to the changing needs and requirements of injured workers and employers.

Agency Response: The department does not agree that the rule will interfere with networks being able to remain responsive to the changing needs and requirements of injures workers and employers. The service area is the geographic area or areas in which the network is licensed to do business. During the application review process, only the service area specified in the application will be evaluated by the department for compliance. Consequently, to ensure continued compliance with all requirements, the department must evaluate any modification to the approved service area or areas to ensure continued compliance with all requirements.

§10.26: One commenter states that the proposed rule, including §10.26, does not appear to allow products that include less than an entire service area as certified by the department. Furthermore, the rule does not appear to contemplate the use of customized service areas by those contracting for the services of the certified networks. The commenter notes those utilizing network services might wish to use only certain geographically defined portions of a certified network and requests that the rules be clarified to allow for such configurations. Another commenter states that a network should be able to certify a large multi-county region of the state, but the carrier may have employers who are interested in smaller, perhaps one-county, networks. The commenter requests that the rules allow carriers, networks, and employers greater flexibility with regard to service area arrangements. One commenter supports clarifying that the certification application process will accommodate the simultaneous certification of multiple service areas within one certified network. Another commenter states that a network should also be permitted to present multiple "customized" service areas on a carrier-by-carrier basis for each carrier it has contracted with for simultaneous certification under the Act.

Agency Response: The department believes that the commenters may be confusing service area modifications with modifications to network configuration. Although the rule does not prohibit a customized service area, the department is required to evaluate a customized service area for compliance with adequacy, access and availability requirements. If an applicant is able to include information regarding its customized service areas at the time it applies for certification, the department will evaluate the customized service areas separately for compliance with adequacy, access and availability requirements. If subsequent to certification, a network decides to create a customized service area, then the network must submit a filing in accordance with §10.27.

§10.26 and §10.27: Some commenters raised concerns that use of the word "application" in §10.26 and §10.27 could create some confusion as to whether or not a network must tender the $5,000 application fee required in §10.21 when they seek approval to modify their network configuration or service area. Some commenters recommend that the term "modification request" be used instead of "application."

Agency Response: The department agrees and has changed the term "application" in these sections to "modification request."

§10.26 and §10.27: A commenter states the distinction between modifications to "service areas" (§10.26) and modifications to a "network configuration" (§10.27) is unclear as modifications to both require descriptions and maps of service areas, network configuration information, and copies of the form of any new contracts or existing contracts. The commenter requests further clarification regarding the difference between these two terms.

Agency Response: The department does not agree that the distinction between modifications to "service areas" (§10.26) and

modifications to a "network configuration (§10.27) is unclear. Changes in service area and changes in network configuration are distinct events. The "service area" is the area or areas in which the network is licensed to do business. An expansion, elimination, or reduction of an existing approved service area results in the modification of the service area which must be approved by the commissioner. "Network configuration" refers to the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees. Any change to the network configuration that is material to the adequacy of the network to provide comprehensive health care services requires a filing to modify the network configuration as provided in §10.27.

§10.26 and §10.27: A commenter notes that the rule does not establish a fee for modifying a network's configuration, and the commenter supports the policy determination to not charge a fee for the modification of a network's configuration. According to another commenter, should the commissioner charge such a fee, there are questions about whether network turnover would be defined as a change. This could be a significant issue in larger networks where such changes could occur often.

Agency Response: The commenter is correct that the filing and approval of network modification will not require a filing fee. The department will not require a filing every time a provider joins or leaves the network. However, should such changes, in whole or in part, alter the ability of the network to provide comprehensive, accessible, available health care services sufficient to serve the population of injured employees, the network would have to submit an application to modify the network configuration prior to the modification so that the department can determine whether the adequacy requirements will be met.

§10.26(a): A commenter feels that only those with the ultimate fiduciary authority within the network should attest to the truth and accuracy of the information in the modification request and recommends that the subsection be changed to specifically state that "The Chief Executive Officer (CEO), Chief Financial Officer (CFO) or President" must verify the application by attesting to the truth and accuracy of the information in the application.

Agency Response: The department declines to make the commenter's change because the subsection contains language required by the Act in §1305.052(b)(2).

§10.26(c)(2): One commenter opines that the narratives required under this part of the rule should be subject to open records.

Agency Response: The narratives are subject to the confidentiality requirements in Insurance Code Chapter 1305 and the Public Information Act. The department will comply with these requirements.

§10.26(f): Some commenters believe that the notice of network requirements should suffice in place of a signed acknowledgment form.

Agency Response: The department disagrees. If the network expands its service area, it is possible that employees who were formerly not living within the service area of the network will now be subject to network requirements. Therefore, the employer must furnish notice and an acknowledgment form to employees affected by the change in service area, as required in Insurance Code §1305.005(d) and §1305.451. Carrier notice requirements in §10.60(b) would also be triggered by such a change.

§10.27: Several commenters express concern about the requirement for approval of "material" modifications to network configuration. According to one commenter, no definition of the term "material" may mean that a network's change of even a single provider would require an application for approval with the department. The commenter observes that this creates a disincentive for certified networks to add providers or to remove poor-performing providers in order to avoid the hassle of having the resulting modification to the network configuration approved. The commenter requests that §10.27 be revised to include a broad definition of the term "material" to ensure that certified networks have the ability to continue building or improving networks. Another commenter suggests defining "material," as a loss of 25% of the network's contracted providers or the loss of a key trauma hospital facility. Another commenter suggests that "material" be defined and that the phrase "greater than 10%" be included after "configuration." One commenter opines that there is no justifiable reason why the department should require this information and that no disincentives should be arbitrarily created that would hamper network improvements after certification.

Agency Response: The rule does not require a filing every time a provider joins or leaves the network. However, under the rule, should any changes to the configuration of providers, in whole or in part, alter the ability of the network to provide comprehensive health care services sufficient to serve the population of injured employees, the network would have to submit an application prior to modification of the network configuration. This is necessary to enable the department to determine whether network adequacy standards are met. At this time, the department declines to define the term "material." The department will determine materiality by analyzing the documentation submitted by the networks. In addition, defining "material" to mean "the loss of 25%" of the network's contracted providers or "greater than 10%" could lead to limiting the factors by which "material" is evaluated. The department will monitor modifications to determine whether the term "material" should be defined.

§10.27: A commenter requests that the department delete §10.27 in its entirety because in the group health plan arena, the department does not approve changes in network configuration and the Act does not mandate this requirement. In the alternative, to ensure that certified networks can continue to build or improve networks, the commenter requests that §10.27(a) be revised to include the following statement: "A change that does not adversely affect the network's ability to meet its statutory requirements under Chapter 1305 of the Insurance Code or §10.80 of this section is not material."

Agency Response: The department declines to delete this section. Insurance Code §1305.053(9) requires a network to provide a list of all contracted network providers that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate that the access and availability standards are met. Accordingly, the department must require these filings to determine and to ensure compliance with the adequacy requirements.

§10.27(a): One commenter states that there should be no need for approval of modifications to network configuration when there has been a gain in providers since this would increase accessibility and availability. The commenter also questions how the department can "approve" changes to network configuration, when the termination of network providers may well be outside the net-

work's control and will almost certainly be outside the department's control. The commenter opines that, because contracting with a workers' compensation health care network is a provider's voluntary business decision, changes in the network configuration would seem to be handled more appropriately as informational filings than as filings for approval.

Agency Response: The rule does not require a filing every time a provider joins or leaves the network. However, under the rule, should any changes to the configuration of network providers, in whole or in part, alter the ability of the network to provide accessible and available comprehensive health care services sufficient to serve the population of injured employees, the network would have to submit an application prior to modification of the network configuration. This is necessary to enable the department to determine whether network adequacy standards will be met. It is the department's position that the commenter's recommendation is not consistent with the department's statutory obligations. Under the commenter's recommendation, an informational filing would not occur until 30 days after the modification took place, and the department would not be able to determine network adequacy in time to prevent modifications that would affect the health care needs of injured employees.

§10.27(a): A commenter states that there should be a means by which the public can voice opposition or provide input to the modification of the network configuration.

Agency Response: The statute does not provide a means by which the department can solicit the public's input on modifications to the network configuration. However, the public may provide any input to the department by filing complaints or submitting inquiries to the department. The department utilizes complaints and public inquiries to monitor compliance with insurance laws and department rules.

§10.40: A commenter states that requiring the prior approval of management contracts, including amendments to existing contracts, is unworkable, unnecessary, and expensive, and will create uncertainty and ambiguity in the regulation of networks as well as make networks less responsive to the needs of injured workers.

Agency Response: The legislature in §1305.102(a) requires the prior approval of management contracts. Therefore, any costs are a result of the enactment of the statute, and are not the result of the adoption of the rule. The department is unclear why the commenter believes that the approval process for management contracts will make networks less responsive to the needs of injured workers. However, for consistency with Insurance Code §1305.102, the department is correcting an erroneous reference in this section and adding language to clarify that the approval is by the commissioner.

§§10.40, 10.41 and 10.42: Some commenters recommend that these sections related to contract requirements contain confidentiality clauses to prohibit public access to proprietary information. Another commenter requests that all function descriptions and reporting requirements outlined in this part of the rule should be available to the public pursuant to the Texas Open Records Act.

Agency Response: Pursuant to Insurance Code §§1305.102(k), 1305.152(a), and 1305.154(a), management contracts, network-carrier contracts, and network contracts with providers are confidential and not subject to disclosure as public information under Government Code, Chapter 552. The department does not have the authority to make available to the public any parts of the contracts that are statutorily confidential.

§10.41: A commenter states that §10.41(a)(6) does not address whether a carrier must first delegate contracting, quality improvement, and credentialing to the network and that §10.41(a)(9) does not address whether the carrier can reassume the provider contracting, quality improvement, and credentialing functions listed in Insurance Code §1305.154(b) of the statute. Therefore, the commenter requests that the rules be changed to consistently state that the responsibilities and functions of a network are only those delegated by a carrier and that a carrier is authorized to reassume any and all functions delegated if necessary, including those set forth in §1305.154(b) of the statute. Further, the commenter recommends that the rule include a provision that would allow the department to grant a carrier an immediate temporary certification so that the carrier can assume network functions. Another commenter requests that the department clarify the terms "delegated entity" and "delegated functions" to clarify which services may be delegated by both carriers and networks and to state that a network may qualify as a delegated entity of a carrier, while a downstream entity may be a delegated entity of a network.

Agency Response: Under Chapter 1305, a network is exclusively responsible for quality improvement, credentialing, complaints and contracting with providers within the network. These functions are not delegated from the carrier, but the carrier must see that they are performed correctly. A carrier, however, may delegate any other function to the network by contract, but the carrier must perform oversight and reassume the functions if the network fails. A carrier may also delegate functions to third parties, such as utilization review and claims payment processing. A network may delegate its exclusive functions or any delegated function to a third party. Section 10.41(a)(9) requires network-carrier contracts to include a provision establishing a contingency plan under which a carrier would reassume quality assurance and other functions. Carriers can structure carrier-network contracts to include an assignment clause. The department does not agree that any change is needed in these sections.

Whether delegated or not, a carrier can reassume functions because these provisions specifically address a contingency plan. Section 10.41(a)(9) requires network-carrier contracts to include a provision establishing a contingency plan under which a carrier would reassume quality assurance and other functions. Carriers can structure carrier-network contracts to include an assignment clause. The department declines to make this suggested change. A network is exclusively responsible for quality improvement, credentialing, complaints and contracting with providers within the network. These functions are not delegated from the carrier, but the carrier must see that they are performed correctly. A carrier may delegate any other function to the network by contract and must perform oversight and reassume the functions if the network fails. A carrier may also delegate functions, such as utilization review and claim payment to third parties. A network may delegate its exclusive functions or any delegated function to a third party.

§10.41: A commenter recommends adding a requirement for carriers to pay in accordance with the network-provider contract because group health carriers and self-insurers accept the contracted discounts, but then add their own claim adjudication rules that are different from those described in the network-provider contract.

Agency Response: The department agrees that carriers and self-insurers must pay in accordance with the network-provider contract and will monitor complaints and consider possible future action, including rulemaking, if the commenter's concerns materialize.

§10.41(a): A commenter requests that the network-carrier contract contain an additional subsection stating that a reasonable transition period is allowed for certain injured employees already receiving care, during which they can continue to see their current, non-network physician for a minimum period of 120 days and up to one year.

Agency Response: Insurance Code §1305.103(c) requires an injured worker who is being treated by a non-network provider to select a new provider within 14 days of receiving the required notice of network requirements. The department does not have the authority to make the requested change.

§10.41(a)(3): Some commenters note that §10.41(a)(3) requires the contract to be terminated immediately if cause exists, but that what constitutes cause is not defined. Because this may prevent networks and carriers from working together to resolve problems, one commenter recommends revising the rule to set forth what constitutes cause and require that the breach be repaired within a specified time frame.

Agency Response: The statute in Insurance Code §1305.154(c)(3) requires the contract to be terminated immediately if cause exists. Section 10.41(a)(3) is consistent with the statutory language. The department declines to amend the rule to define cause or to require a breach to be repaired within a specified time frame because a carrier or network may define cause in a contract. This approach allows for more flexibility between the carrier and network in the contracting process.

§10.41(a)(7): A commenter states that it is in the best interest of the public that language be added to subsection (7) to read: (I) data in sections (paragraphs) (C), (E) and (F) of §10.41(7) are subject to the Public Information Act and shall be provided to interested parties upon request.

Agency Response: The department does not have the authority to add the suggested language as the legislature, rather than the department, determined whether particular information is subject to the Public Information Act. In addition, the Public Information Act applies only to governmental bodies, not private entities.

§10.41(a)(7)(A), (B) and (C): Some commenters request that the monthly reporting requirements in §10.41(a)(7)(A) and (B) be modified so that social security numbers, dates of birth, addresses and phone numbers of employees are not required to be reported because of privacy concerns and state that carriers, due to delegation agreements, already possess this data. Another commenter requests that the original informal draft rule language, which required more data elements than the current version, replace the proposed language to give the department the tools and information needed to thoroughly scrutinize the performance of the networks.

Agency Response: The department declines to either reduce or increase these data reporting requirements. Insurance Code §1305.154(c)(7) requires networks to provide carriers with the data the carrier needs to comply with the reporting requirements of the department and the Division with respect to any services provided under the contract, as determined by commissioner rules. The Division already collects this information, and the department has access to this claim information pursuant to Labor Code Chapter 402.085 (related to Exceptions to Confidentiality).

§10.41(a)(9): A commenter notes that the proposed rules do not include a rule that parallels Insurance Code §1305.155, which generally sets forth the process for ensuring that a network complies with the network-carrier contract. The commenter asserts that, to the extent that §1305.155(g)(3) refers to selection of treating doctors under the ADL, the rules should clearly state that this option may only be required by the department if it is included in the applicable network-carrier contract's contingency plan. This is consistent with the enforcement powers granted to the department by Chapter 1305, which permit the department to require a carrier to comply "with the contingency plan required by §10.41(a)(9), including permitting an injured employee to select a treating doctor" from the ADL. If the department has approved a contingency plan that does not include this option as part of the network certification process, then the commenter suggests that the carrier should be required to enforce only the provisions of the contingency plan, as approved, and should not be required to permit employees to use the ADL to select treating doctors.

Agency Response: Insurance Code §1305.155 gives the commissioner the authority to order a carrier to take any action necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act. Whether a carrier's filed contingency plan is sufficient to provide those services will be determined on a case-by-case basis in accordance with §1305.155.

§10.41(a)(9): A commenter states that the requirement for a contingency plan includes the network function of payment to providers and requests that this provision be deleted because networks do not pay providers.

Agency Response: The department agrees with the commenter's concern and is adding the language "as applicable" to §10.41(a)(9)(A) for clarification. The "as applicable" language is necessary because some networks may perform payment functions under a delegation agreement with a carrier, in which case this function would be applicable.

§10.41(a)(9)(D): A commenter states that there should be no need for retrospective review if services are preauthorized.

Agency Response: The department agrees because Insurance Code §1305.153(b) prohibits retrospective review of a health care service that has been preauthorized by an insurance carrier or network, except for reasons other than medical necessity. However, not all services will be subject to preauthorization, and therefore this language is necessary.

§10.41(a)(15): A commenter asserts that it is in the public's interest to make all complaint documents available under the Public Information Act. The commenter recommended a language change to require that the documents be made available to the carrier and any requestor upon request.

Agency Response: The department declines to make the change. The Public Information Act is applicable to governmental bodies, and not private entities. The networks have possession and control over the complaint log and complaint files, which are not subject to open meetings and open records laws. Insurance Code §1305.403(d) specifies that the complaint log and complaints are available to the department during any investigation or examination of a network, but does not provide for any other disclosure of the complaint documentation (except for the complainant for information related to the complaint). It

is the department's interpretation that the department does not have the authority to provide for any further disclosure than that provided in the statute.

§10.41(a)(15): A commenter requests that §10.41(a)(15)(B) be changed to make the complaint log and complaint files available to the carrier and the provider within 30 business days of written request. Another commenter states that the requirement for a network to make complaint files available should be restricted to that information in those files as is permitted under applicable privacy, confidentiality, and security laws. The commenter believes such a limitation will assist in clarifying what information can actually be made available under this regulation.

Agency Response: Section 10.41(a)(15)(B) requires networks to make the complaint log and complaint files available to the carrier upon request. The department has added the phrase "to the extent permitted by law" at this end of the provision. The department disagrees that the complaint log and complaint files should be made available to the provider. A provider may access the report prepared by the workers' compensation research and evaluation group, under Labor Code §405.0025(c), which will provide information on the impact of workers' compensation health care networks on injured employee satisfaction and the frequency, duration and outcome of complaints and disputes regarding medical benefits. No additional change is required.

§10.41(a)(18): A commenter suggests that, in order to ensure the continuation of benefits for insureds whose carriers become insolvent, the network-carrier contracts should also include language requiring cooperation with the guaranty fund, and suggests adding language requiring a statement that the institution of delinquency proceedings against the carrier resulting in the transfer of claims handling responsibility to a receiver or the Texas Property and Casualty Insurance Guaranty Association or similar association in another state shall not constitute any event for which the contract may be terminated for cause and other related language.

Agency Response: The department notes the commenter's concern for ensuring the continuation of benefits for injured employees. However, Insurance Code Chapter 1305 and these rules do not directly address the insolvency of an insurance carrier. Adding this subject matter to the rule would be a substantive change and would not allow all interested parties to comment on the change The department will monitor the issue for future rule making. The department notes that in the event a network terminates its contract because of delinquency proceedings against the carrier, injured employees could access care from an ADL doctor.

§§10.41(a)(19), 10.42(b)(13), and 10.60(g)(16): A commenter recommends adding new language in three sections to require that networks ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and to state that the Division shall periodically examine whether reasonable access exists.

Agency Response: The department believes the commenter's recommendation is contrary to the statute. Labor Code §413.011(i) provides that the Division of Workers' Compensation shall examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates or any other barriers exist that reduce the ability of an injured employee to access those medical needs. The Division shall recommend to the legislature any statutory changes necessary to ensure appropriate access to those medical needs.

§10.41(b): One commenter agrees that §10.41(b) accurately reflects the rights and authorities of a network by stating that a network's authority to perform a function under a network-carrier contract is conditioned upon whether the carrier has delegated that function to the network in the contract and whether the network is appropriately licensed to perform that function.

Agency Response: The department appreciates the comment. A carrier does not have to delegate credentialing to a network, but the carrier can reassume this function and may add this to the contingency plan, which is intended to address reassumption of functions. A network may also include an assignment clause in the provider contract. Absent an assignment clause, the use of providers on the division's ADL under Labor Code §408.023 may be required.

§10.42: A commenter requests language that will address implementation of a card, similar to a group health plan card, identifying the necessary information to process health care services to the injured employee, requesting that such a card include: employee name; employer name and/or employer group number provided by network or carrier; workers' compensation health care network name or logo; telephone number for verification of employment status; claim submission address; telephone number for authorization and/or precertification; carrier name; and effective date of coverage. The commenter suggests that the card can be coordinated with any state program, as it relates to tracking necessary information. Absent such a card, the commenter requests that language should be included in the contract between the provider and network as to how pertinent information can be identified.

Agency Response: The statute does not include a requirement for identification cards to be issued by carriers or networks. The department declines to create a new requirement that carriers or networks issue such cards or that any cards issued include any specific language. Networks and carriers are not precluded from voluntarily issuing cards. The provider and the network can negotiate how the pertinent information is to be identified in their contract.

§10.42: A commenter requests information to clarify who is responsible for notifying the member that a provider is terminating from the network when a carrier or employer uses a PPO. The commenter also asks how a PPO can continue operations during the transition period if PPOs cannot operate or market themselves as a workers' compensation health care network.

Agency Response: Section 10.42(b)(6)(G) provides for the network to notify employees receiving care of the provider's termination or contract expiration. A PPO that operates as a voluntary health care provider network for the purpose of arranging for and providing health care services to injured employees may not operate or perform the acts of a network, as defined by the Texas Labor Code and Texas Insurance Code, after January 1, 2006. Applications for certification as a workers' compensation network will be accepted by the department starting January 1, 2006.

§10.42: A commenter states that the final rules for workers' compensation should include the prompt pay language related to 30 days for electronic claim submission and 45 days for paper claims. The commenter further states that the final rules should also include the group health penalty language for failure to pay promptly and accurately.

Agency Response: The legislature has set forth a carrier's reimbursement requirements for network care in the statute at Insurance Code §1305.106, which references Labor Code §408.027, and Insurance Code §1305.153. These requirements are the specifically applicable prompt payment requirements for workers' compensation health care network services. The department does not have the authority to substitute the PPO/HMO prompt pay requirements for these statutorily mandated requirements.

§10.42: Although a commenter does not want the department to require that the employer or carrier have an identification (ID) card for every single employee, the commenter acknowledges there needs to be some way to identify that injured worker when the worker schedules an appointment. The commenter encourages the department to explore different options so that there is an easy way to identify the patient is eligible.

Agency Response: The purview of these rules does not include how providers are to identify injured workers upon scheduling an appointment. The department will take this comment into consideration and monitor the situation for future rulemaking as necessary.

§10.42: A commenter states that antitrust regulations prohibit providers from discussing any fee information or proposed fees with any other provider. The legislature included in HB 7 a clause that allowed a network to revise insurance company status for the purposes of negotiating contracts because a network must negotiate a contract with both its providers and also with the insurance companies. The commenter asks that the department consider that any entity that is contracting with providers in an effort to become a network would likewise be included in this exoneration of physician antitrust problems.

Agency Response: Insurance Code Chapter 1305 and Chapter 10 require networks and providers to contract in accordance with other state and federal laws. The department's jurisdiction does not extend to antitrust regulations.

§10.42: Some commenters recommend that the department include the protections created by Insurance Code §1305.153(e) as a mandatory contracting requirement in §10.42 in order to prevent confusion among carriers, networks, and providers. In the event the department chooses not to address §1305.153(e) because it relates to compensability, the commenters urge the department to work with the new Division of Workers' Compensation to address this issue in future rulemaking.

Agency Response: The department declines to make the requested change. The absence of the language in the rule does not affect the applicability of Insurance Code §1305.153(e), as the language in the rule indicates that billing and payment must be performed in accordance with all applicable statutes and rules. However, parties are not precluded from including such a provision in the contract.

§10.42: A commenter requests that the department include a provision indicating that an injured worker or provider is subject to potential liability for administrative or criminal penalties if it is determined that health care services were received, or payment was collected for such services, through acts of fraud or deception.

Agency Response: Nothing in the statute or these rules indicates that a party is exempt from any applicable penalties if a party is determined to be in violation of the Workers' Compensation Act or the Penal Code. The department declines to make the requested change as additional language is not necessary.

§10.42: A commenter requests that the rules specifically implement Insurance Code §1305.1545 and, in particular, §1305.1545(b).

Agency Response: Insurance Code §1305.1545(a)(2) makes reimbursements on a discounted fee basis contingent upon a provider agreeing to the terms of the contract. Subsection (b) prohibits a party to a network-carrier contract from selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of the contract without express prior approval. The department has added some clarifying language in §10.42(b)(14), to ensure that the network-provider contract include a statement that the provider specifically agrees to provide treatment for injured workers who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

§10.42(a): A commenter requests a response or clarification as to the operation of this rule, originating from Insurance Code §1305.152(b). The commenter is concerned that the rule could be interpreted to imply that a network would be required to accept provider into the network if the provider applies before the network has contracted with its intended number of qualified health care providers. The commenter assumes that it is not the intent of the statute or the department that this rule would require networks to accept an application from any willing provider, a concept that was rejected by the Legislature in drafting HB 7.

Agency Response: The department will continue to monitor this issue for future rulemaking. Insurance Code §1305.152(b) does not require that certified networks accept applications from qualified providers if the network determines that it has contracted with a sufficient number of qualified providers. Section 10.42(a) mirrors this statutory language. All applicants must meet the network's credentialing criteria, including those who apply before the network has contracted with its intended number of qualified health care providers.

§10.42(a): Some commenters strongly support §10.42(a), which tracks §1305.152(b) of the statute and provides that a network is not required to accept a provider for participation in the network if the network has a sufficient number of qualified health providers. Commenters request that the rules clearly state that a network has the discretion to determine whether it has a sufficient number of providers and is not required to prove this determination, which the commenters believe is consistent with the department's interpretation of this language for HMOs. A commenter also asks that the rules clarify that a network is not required to provide an appeal process for rejected applicant providers because a notice of rejection is sufficient. The commenter believes such a clarification is consistent with the requirements of Insurance Code §1305.152(c), which only requires a network to provide an appeal for providers whose network provider status is terminated.

Agency Response: The department will continue to monitor this issue for future rulemaking. Insurance Code §1305.152(b) does not require that networks accept applications from qualified providers if the network determines that the network has contracted with a sufficient number of providers. Section 10.42(a) mirrors this statutory language. Thus, the department agrees that a network has no obligation to prove its adequacy to a provider in rejecting an application. The department agrees that providers have no right to appeal a rejected application but

believes that the rules are sufficiently clear without the need for additional clarification.

§10.42(a): A commenter states that the requirement for a "sufficient" number of qualified providers leaves a huge loophole for the carrier-networks to choose providers based on whatever criteria the carrier-network chooses. A commenter requests clarification of the entire §10.42. The commenter believes that the only obstacle to a provider's inclusion in the network should be a provider choice against participation or a provider history of fraudulent practices or overutilization within the traditional workers' compensation system. The commenter believes that any provider who wishes to participate should be allowed to do so.

Agency Response: Insurance Code §1305.152(b) does not require that networks accept applications from qualified providers if the network determines that the network has contracted with a sufficient number of qualified providers. Section 10.42(a) mirrors the statutory language.

§10.42(a): A commenter feels that, to assure that networks contract with health care providers from each discipline and specialty sufficiently to serve the population served by the network, the department should either establish criteria which consider geographic area, types of industry, and number or workers or should require each network to provide a detailed methodology used by the network to establish the number of providers with whom to contract. The commenter believes that injured workers deserve prompt, appropriate care which can only be delivered if an ample number of providers of all disciplines are part of the networks.

Agency Response: The plenitude of factors that may affect a network's ability to deliver care at any given time weighs against introduction of a formulaic methodology for determining adequacy. The department declines to add a requirement that detracts from the flexibility needed to account for the varying circumstances, such as the urban versus rural nature of a service area or the utilization of services in a particular service area. The department's review of network adequacy focuses on the specifics of a service area and other factors that are particular to the network in question.

§10.42(a) and (b)(5): One commenter states that the network should be protected regarding provider selection and deselection so the network can freely pick doctors; and if doctors don't comply with the rules, the networks can either reeducate them or kick them out of the network without fear of litigation.

Agency Response: Insurance Code Chapter 1305 and the rules provide networks the freedom to select and deselect doctors. Section 10.42(b)(6) as adopted requires a contractual provision regarding appeal of a provider's network status but does not prohibit the network from deselecting a provider in accordance with the rules. Under §10.42(b)(6) networks may terminate providers immediately in the case of imminent harm to patient health, suspension or loss of license to practice, or fraud.

§10.42(b): A commenter requests that §10.42(b) be deleted as too onerous for providers. Another commenter requests that subsection (b)(12) ((b)(13) as adopted) be changed to require that network-provider contracts include a statement that billing by and payment to the provider will be made in accordance with department rules under Senate Bill 418. Another commenter requests inclusion of a clause requiring networks to provide a minimum 90-day prior written notice to providers of a requested change in contract fee allowable.

Agency Response: The provider contract requirements are largely derived from Insurance Code §1305.152 (related to Network Contracts with Providers). The statute does not apply the prompt payment standards set forth in Senate Bill 418 (78th Regular Session) to services provided under a workers' compensation health care network contract. However, the legislature does impose the standards in Labor Code §408.027 for payment of network providers. The department does not have the authority to make the requested changes.

§10.42(b)(1) and §10.60(e)(2)(B) and (g)(7): A commenter states that under the statute, a hospital or other providers risk non-payment by the carrier in many situations. While the commenter believes it is reasonable to prohibit providers from billing employees in those situations in which the employee has no involvement or control, such as the insolvency of the carrier, the commenter believes that the hold-harmless language in §10.42(b)(1) is overbroad and prevents a network provider from billing an employee for health care services for compensable injuries under any circumstances. The commenter believes that §10.60(e)(2)(B) and (g)(7), which provide employees with information about the hold-harmless provision, are similarly broad. A commenter recommends that the department revise §10.42(b)(1) and §10.60(e)(2)(B) and (g)(7) to limit the hold-harmless provisions to those circumstances in which the carrier has not paid the provider due to insolvency or in which the network provider has failed to comply with its contractual obligations. The commenter further recommends that the hold-harmless provisions be changed to allow the patient to pay for services not authorized by the network when the patient has been informed prior to service that the service is not covered and will be the patient's financial responsibility.

Agency Response: The language of §10.42(b)(1) is similar to the language in Insurance Code §1305.152(c)(1), which includes the phrase "under any circumstances." The rule clarifies that the health care services must be related to a compensable injury, which expresses the department's interpretation of the statute that injured employees may not be billed by network providers for health care services for compensable injuries. The commenter's suggested change, which would allow the network provider to bill the injured employee if the carrier failed to pay the provider according to the terms of the provider contract, conflicts with the statute. The carrier's breach of the contract does not allow the provider to pursue payment from the injured worker. The department, however, recognizes the potential for circumstances where the injured worker may be liable for services on a case-by-case basis.

§10.42(b)(2): A commenter states that §10.42(b)(2) requires that network contracts with providers contain language that contractually obliges providers to adhere to the guidelines and protocols utilized by the network and states a belief that there is a lack of treatment guidelines appropriate for physical therapy. For any guidelines and protocols that are imposed by a network, the commenter recommends that, prior to final signature, the network be required to make such guidelines and protocols available to providers as addenda to proposed contracts. Since networks must have such guidelines and protocols in place in order to apply for certification as workers' compensation health care networks, the commenter believes this is a feasible requirement. The commenter states that providers are unable to realistically assess their ability to provide services at the rates proposed without knowing the detail of the network's operating requirements. Another commenter expresses fear that if guidelines and proto-

cols are not reviewed by providers in advance there will be disruptive cancellation and turnover in the provider lists.

Agency Response: Section 10.83(c) requires networks to make adopted treatment guidelines accessible to providers. The department agrees that it would be prudent for a provider to request an opportunity to review such guidelines prior to entering a contract that obligates the provider to follow such guidelines.

§10.42(b)(2): A commenter states that because there are no comprehensive treatment guidelines for physical therapy services for injured workers that meet the requirements of the statute, a provision should be added to §10.42(b) requiring provider contracts to include a statement that requires preauthorization for physical therapy services not addressed in the networks' treatment guidelines, return-to-work guidelines and individual treatment protocols. The commenter believes that the provider's professional judgment and the best interests of the employee may indicate different and/or additional services than those outlined in adopted guidelines. The commenter believes that required preauthorization of services would alert the network and carrier of the need for specific services and allow case management and utilization review to determine what services will be allowed and reimbursed.

Agency Response: The department declines to make the suggested change because the statute does not mandate preauthorization of physical therapy services.

§10.42(b)(2) and (c): A commenter suggests additional language to require the inclusion in provider contracts of a statement that the provider agrees to provide the health care reasonably required to treat the employee's injury in accordance with Labor Code §401.011(22-a) for injuries not addressed in the network's treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by the network. A commenter also suggests that the term "medically necessary services" in §10.42(c) be changed to "the health care reasonably required to treat the employee's injury per Labor Code Section 401.011(22-a)."

Agency Response: The department declines to make the suggested change because networks and carriers are required to provide medically necessary care to an injured employee.

§10.42(b)(3) and §10.60(g)(12)(D)(ii): A commenter has concerns about how complaints from employees and providers will be handled. Section 10.42(b)(3) and §10.60(g)(12)(D)(ii) state that a network cannot retaliate against an employee or a provider because they have "reasonably" filed a complaint against the network in some form. The commenter believes it is critical to encourage individuals to participate in the complaints process in the statute and thinks it is imperative that injured workers feel that they have the ability to notify decision makers of problems with faith that the complaint will be treated appropriately.

Agency Response: Insurance Code §1305.404 prohibits a network from engaging in retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network. Section 1305.404 does not include the term "reasonably" in reference to the filing of the complaint. The term "reasonably" is included in the rule to maintain consistency with the provisions of the statute in §1305.451(b)(10)(B), which includes the "reasonably" qualifier for complaints made by providers. This distinction requires a more discerning attitude towards complaints from providers, but does not have a chilling effect on complaints from employees who do not have the same professional expertise as providers. The department believes that the rule adequately addresses the concerns raised by the commenter.

§10.42(b)(3): A commenter states that the phrase "reasonably filed a complaint" is vague and ambiguous. The commenter is unclear whether the term "reasonably" is meant to indicate a requirement that the complaint be reasonable or a requirement that the manner in which a complaint is filed be reasonable. The commenter requests that the phrase be defined or restated. The commenter also suggests that the word "employee" should be changed to "injured worker."

Agency Response: The term "reasonably" is meant to characterize the nature of the complaint rather than the method of filing the complaint. The term "employee" is defined in Insurance Code §1305.004(a)(8) by reference to Labor Code §401.012 and is broad enough to include injured workers. The department believes the rule is clear and does not require a change.

§10.42(b)(4)(A): Commenters request the insertion of language to specify that networks, rather than providers, have the authority to determine whether an employee has a life-threatening condition or an acute condition for which disruption of care would harm the employee.

Agency Response: The department declines to make the recommended change. The department believes that physicians and providers who have first hand knowledge of the employee's health status are best positioned to determine whether the injured employee has a life-threatening condition or an acute condition for which disruption of care would harm the employee.
§10.42(b)(4)(A): A commenter recommends that the term "acute" be defined to avoid abuse and notes that California has defined "an acute condition" as "a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of less than 90 days."

Agency Response: The department declines to make the requested change. The department believes that the term "acute" is so widely used in the medical field as to have a plain, commonly accepted meaning. Whether an injured employee's condition is acute is a question that should be determined on a case-by-case basis, but the department will monitor this issue in order to determine whether future rulemaking is appropriate.

§10.42(b)(4)(A): A commenter suggests adding language to indicate that the requirement for a carrier or network to continue reimbursement of a provider for an employee with a life-threatening or acute condition for which disruption of care would harm the employee may not exceed 90 days.

Agency Response: The language in the rule provides that the time cannot exceed 90 days.

§10.42(b)(5)(A): A commenter recommends that the adopted rules should not include a 90-day notice for terminations for cause.

Agency Response: The 90-day notice requirement is required for all terminations except in case of imminent harm to patients, suspension or loss of license to practice, or fraud. The department believes that the 90-day period allows for a timely appeal process should the provider choose to appeal, and also provides an opportunity during the 90-day period for the provider to cure the deficiency.

§10.42(b)(5)(B): Commenters state that the requirement that the network provide an advisory review panel to review terminations comprised of at least three network providers of the same specialty or similar specialty is unreasonably burdensome. Another commenter states that an advisory panel comprised of network providers within the network is a bad idea. An additional commenter suggests that the required advisory panel should consist of providers with like licenses because the "same or similar specialty" language will leave the panel makeup so ambiguous as to cause disputes. Another commenter believes the term "same or similar specialty" needs to be defined and/or clarified. Another commenter recommends that the panel members should have "the same or similar license and specialty."

Agency Response: The like specialty review panel is used for group health and has been included in the rule to make the network proximate group health services. The adopted rule allows networks greater flexibility by allowing network and non-network providers to serve as members of the network's advisory review panel. The department agrees that advisory panel members should be of the same licensure as the provider appealing a termination and has changed the rule accordingly.

§10.42(b)(5): A commenter states that it is impossible for the network to know which injured employees are seeing providers in its network, so the network cannot provide notice of termination to injured employees. The commenter further suggests language to state that the network may provide notice to injured employees through updates to the network's provider directory or through provider communications.

Agency Response: The department disagrees. The required contractual provision at §10.41(a)(7) of these rules states that the network must report to the carrier on at least a monthly basis the names, as well as other information of each injured employee who is being served by the network, as well as each injured employee's treating doctor. Therefore, a certified network must have a method for collecting information about injured employees being treated by network providers. The required notice to injured employees receiving care must be given directly to the employees in order to allow them to find another provider. Updates to the provider directory will serve as notice to other employees who are not receiving care from the terminated provider.

§10.42(b)(5): A few commenters request a change to indicate that a provider has no right of appeal for termination based upon the natural expiration of the contract's term. A commenter also asks whether written notification of the termination should be provided to a provider's patients rather than all employees.

Agency Response: The department agrees and has changed §10.42(b)(5) (§10.42(b)(6) as adopted) to clarify that the required provider contract provision relating to appeal of a termination of network provider status does not apply in the case of a termination due to contract expiration. The department has also added language in §10.42(b)(6) as adopted to clarify that the requirement to give written notification to employees of a provider termination is limited to "employees receiving care" from the terminated provider.

§10.42(b)(5)(G): Commenters request that §10.42(b)(5)(G) be changed to reflect that a network must provide notification of a termination of contract to employees receiving care whether the network or the provider terminates the contract.

Agency Response: The department agrees and has added language in adopted §10.42(b)(6) as adopted to provide that network contracts with providers must include a statement that if the network or the provider terminates the contract, the network must provide notification of the termination to employees receiving care from the terminating provider.

§10.42(b)(6): A commenter asks if the notification to employees regarding the process for resolving a workers' compensation health care network complaint will be provided by or available to all providers through the department, printed in several languages to accommodate workers who do not read English, to assure standardization of size and statement. If the notification is not available through the department, the commenter requests that §10.42(b)(6) be changed to address all content aspects of the notice.

Agency Response: The department declines to promulgate such a form but will consider making a sample form available on the department's website. The department declines to make the requested change to §10.42(b)(6).

§10.42(b)(10): A commenter recommends that the language in this provision mirror the group health language and include a requirement that the network provide any and all claim adjudication rules in addition to the fee schedule.

Agency Response: The provider protections associated with prompt payment provisions are actually located in Insurance Code §1305.106, which incorporates the requirements under Labor Code §408.027 by reference. The commenter's suggested change can be a negotiated requirement for the network contract with the provider.

§§10.42(b)(10), 10.42(b)(2), and 10.83: A commenter asks which fee schedule applies and requests use of a single fee schedule, stating it will be problematic if there are multiple differing guidelines and protocols providers must follow if the providers contract with multiple networks.

Agency Response: Each networks' fee schedule for each provider will be negotiated during the contracting process. Additionally, Insurance Code §1305.304 requires each network to adopt its own treatment guidelines and protocols. The department declines to make the requested change.

§10.42(b)(10): A commenter requests clarification about the requirement that the contract include a schedule of fees and asks if this means that the contract must include an actual fee schedule or merely reference a benchmark.

Agency Response: The contract may use benchmarks, including, but not limited to Medicare and Medicaid, as a reference for the fee schedule. The contract also may include a fee schedule for specific billing codes. The format of the fee schedule is subject to the contract negotiation process between the network and the provider.

§10.42(b)(10): One commenter is concerned about the lack of a fee schedule. The commenter states that it is difficult for physicians to be able to practice and to consider treating workers' compensation patients if the reimbursement is going down. Another commenter requests that a reimbursement floor be established by rule. The commenter has concerns about the level of reimbursement when some pre-certification contract negotiation indicates that some networks might offer 85% of Medicare.

Agency Response: Network contracts with providers must contain a schedule of fees that will be paid to contracting providers. Under Insurance Code §1305.153(a), the amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or group

of providers. The statute does not provide for the establishment of a reimbursement floor by rule.

§10.42(b)(12): A commenter strongly supports §10.42(b)(12) and thinks that provision should require the inclusion of a prompt pay provisions in network-provider contracts, which are similar to those included in the HMO and PPO contracting rules, which will help to ensure that network providers will be paid timely for their services and will be given the ability to enforce their statutory payment rights. The commenter requests that §10.42(b)(12) be changed to encompass the payment protections created by the statute for network providers under Insurance Code §1305.106, to require inclusion in the network-provider contract a provision which states that billing by and payment to the provider will be made in accordance with Insurance Code §1305.153 (related to Provider Reimbursement) in addition to Labor Code §408.027 and other applicable statutes and rules.

Agency Response: The department declines to include a prompt pay provision in network-provider contracts, which are similar to those included in the HMO and PPO contracting rules. The legislature has set forth a carrier's reimbursements requirements for network care at Insurance Code §1305.106, which references Labor Code §408.027, and Insurance Code §1305.153. These requirements are the specifically applicable prompt pay requirements for workers' compensation health care network services. Insurance Code §1305.106 requires carriers to pay claims only in accordance with Labor Code §408.027. Insurance Code §1305.153(d) states that subject to Subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter, but does not require that any specific statutes or rules be listed in the network-provider contract. Section 1305.153(a) states that the amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider. The department declines to add a required reference to the language in Insurance Code §1305.153, because portions of the section are not applicable to contracted providers, and those sections that do apply will not be rendered inapplicable by the lack of a reference to the section. The actual contractual provision may be negotiated but must comply with the spirit of proposed §10.42(b)(12) (§10.42(b)(13) as adopted). The department will monitor the situation for possible future rulemaking.

§10.42(b)(12): A commenter asserts that all the prompt pay provisions that exist under Senate Bill 418 should be applicable, including proof of filing, penalties for not paying claims on time, and some other issues that have been left out in HB 7. In addition, the commenter believes the network should be able to contract with carriers to include additional prompt pay provisions not included in HB 7. Another commenter supports prompt pay and appreciates every aspect of prompt pay that can be put into rules.

Agency Response: The department declines to make the change to §10.42(b)(12). The legislature has set forth a carrier's reimbursement requirements for network care at Insurance Code 1305.106, which references Labor Code 408.027, and Insurance Code 1305.153. These requirements are the specifically applicable prompt pay requirements for workers' compensation health care network services. Insurance Code §1305.106 states that Labor Code §408.027 (related to Payment of Health Care Provider) applies to a carrier's payment, reduction, denial, or determination to audit a claim for services provided through a workers' compensation health care network. Insurance Code §1305.153(d) states that subject to subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter. Section 1305.153(a) states that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider. Carriers, networks and providers are not precluded from negotiating additional prompt pay provisions in accordance with Labor Code §408.027 and other applicable statutory and rule provisions.

§10.42(b)(12) and Labor Code §413.011: A commenter encourages the adoption of a fee schedule because it helps to set a threshold from which any contracting can take place and helps the parties to understand the basis from which they are going to start. Another commenter requests that networks be allowed to negotiate with physicians for fees that would exceed the current fee guidelines under the workers' compensation system.

Agency Response: The department does not have the authority to adopt a fee schedule. Insurance Code §1305.153 provides that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider or group of providers. Section 10.42(b)(12) (§10.42(b)(11) as adopted) requires network contracts with providers to contain the schedule of fees that will be paid to the contracting provider. The parties are free to negotiate the schedule of fees.

§10.42(b)(14): One commenter indicates concerns regarding the lack of penalties for those who disregard their own contracts; i.e., while the contracts contain prompt payment for clean claims, there is no penalty for untimely payments. On the other hand, the commenter notes that if a provider does not submit a clean claim in the time specified in the contract, payment won't be made.

Agency Response: Pursuant to §10.42(b)(14) (§10.42(b)(13) as adopted), provider contracts and subcontracts shall include a statement that billing by and payment to the provider will be made in accordance with Labor Code §408.027. Carriers who fail to comply with Labor Code §408.027 are subject to administrative penalties under the Insurance Code and Labor Code, as applicable. Parties are free to negotiate penalty provisions in their contracts.

§10.42(c): Commenters request that the rules clarify that pay-for-performance standards may be adopted by networks without violating the prohibition in Insurance Code §1305.152(e) (related to prohibited financial incentives), in order to be consistent with HB 7, which tasks the commissioner of workers' compensation with promoting compliance with the workers' compensation system through performance-based incentives and developing performance-based oversight of carriers and providers through incentives. Another commenter suggests that language stating that provider compliance with adopted treatment guidelines, return-to-work guidelines and individual treatment guidelines is not a violation of §10.42(c).

Agency Response: The department agrees that if pay-for-performance guidelines are adopted by the commissioner of workers' compensation that meet the requirements of Insurance Code §1305.152(e), then the guidelines would be allowed under §10.42(c). However, the department does not believe additional language is necessary to clarify this point. Section

10.42(c) specifies that the adoption of treatment guidelines, return-to-work guidelines, and individual treatment protocols by a network under Insurance Code §1305.304 and §10.83(a) of this chapter (relating to Guidelines and Protocols) is not a violation of §10.42(c). Because providers are required to comply with adopted treatment guidelines, the provider does not violate §10.42(c) by following those treatment guidelines.

§10.42(d): A commenter supports §10.42(d), but requests additional language stating that either a general notification to providers or the addition of a provision in the network's contracts with providers stating that the network conducts economic profiling would satisfy the requirement to notify providers before the network conducts the profiling. The commenter also requests that the department change §10.42(d) to clarify that economic profiling restrictions relate only to the network application process and not to other medical payment data used in the claims process.

Agency Response: It is not necessary to add language relating to the economic profiling notice. Section 10.42(d) requires a carrier or network to provide written notice to network providers prior to conducting economic profiling. The notice may be a provision added to provider contracts, or it may be a general notification to providers, as long as the network assures that each provider or group of providers receives the notice. The notice requirement related to economic profiling relates to individual profiling of a provider or provider group, rather than aggregate data that may be profiled. An example of such individual profiling is that of utilization management studies that compare the provider or provider groups to other providers. Neither Insurance Code Chapter 1305 nor these rules prohibit a provider from negotiating the provision of additional information as part of the contract with the network if the provider so desires.

§10.42(d): Commenters ask that the provision in §10.42(d) requiring a carrier or network to provide written notice to providers before conducting utilization management studies comparing the provider to other providers be deleted, due to the commenters' belief that the prior written notice would confound the results of what was intended to be an objective study of provider utilization management.

Agency Response: The department declines to remove the provision and agrees to remove the word "any" before "economic profiling" to clarify the carrier and network are not required to provide notice each time a study is to be performed. The carrier and network are only required to give a general notice to providers that economic profiling will be conducted, either at the time of contracting or at a subsequent date when profiling is instituted. Therefore, any skewing of results will be minimal. The reference to utilization management studies is offered only as an example of a type of economic profiling and is not intended to be a limitation.

§10.42(d): Commenters support the proposed rule allowing networks to conduct economic profiling of providers under §10.42(d) and as allowed by the statute. Another commenter requests that the language in §10.42(d) be expanded to require that the network and carrier notify providers in advance of the contract with a more detailed explanation of the standards and methods used by a network in the course of economic profiling than is currently required by the proposed language which could allow for selective economic profiling, something that should not be allowed.

Agency Response: The department declines to add the requested language. If general notice of economic profiling is provided during the contracting process, the provider may ask for standards and criteria at any time or may negotiate a contract provision requiring such information to be given to the provider. If the notice is given after the provider has contracted with the network, the provider may request such information from the network. The rule language only requires that notice be given. It doesn't address the timing except for the fact that the notice must be prior to profiling. The department recognizes that economic profiling of providers is an integral part of managed care and believes that providers should receive notice prior to implementation of profiling. Insurance Code §1305.303(h) requires each network to implement a documented process for the selection and retention of contracted providers in accordance with the rules adopted by the commissioner. Accordingly, §10.42(d) requires insurance carriers or networks to provide written notice to network providers before the carrier or network conducts economic profiling, including utilization management studies comparing the provider to other providers, or other profiling of the provider or group of providers. The department will monitor this issue.

§10.42(e): A commenter requests that patients be permitted to obtain durable medical equipment (DME) from any licensed pharmacy provider because workers' compensation pharmacy benefits are not required to be provided via a network, requests additional language indicating that DME providers are not required to contract with a network to participate in the workers' compensation system, and asks that the provision of DME through a pharmacy or pharmacy's agent be permissible.

Agency Response: The department disagrees because the provision of DME is not a pharmacy service. Insurance Code §1305.101(c) states that prescription medication or services as defined by Labor Code §401.011(19)(E) may not be delivered through a network. Insurance Code §1305.004(b)(4) defines "health care" by reference to Labor Code §401.011(19), which includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations and services. Under Labor Code §401.011(19)(F) "a medical or surgical supply, appliance, brace, artificial member, or prosthesis . . . ." is included in the definition of "health care" but distinguished from prescription medication or services. Therefore, reasonable and necessary DME services can be network services. If a pharmacy is also a DME provider, it may choose to contract with a network in that capacity, although not as a provider of pharmacy services.

§10.60: A commenter requests that §10.60 be amended to allow a carrier to act on behalf of an employer who fails to deliver the statutory notice of network requirements and acknowledgement form to their injured employees. The commenter further requests that a carrier be permitted to deliver the statutory notice via certified, return receipt mail and that the certified, return receipt mail signed by the injured employee be deemed to be the injured employee's acknowledgement of the receipt of the statutory notice of network requirements.

Agency Response: Under Insurance Code §1305.005 the employer is generally the party responsible for delivering the notice of network requirements to employees, including all the information required by §1305.451, and that it is the employer who is required to obtain a signed acknowledgment form from each employee, except in certain specified instances. Therefore, the department declines to make the requested changes. The department, however, is not aware of any provision that would prohibit the carrier from delivering the statutory notice of network require-

ments and acknowledgment form if the employer fails to take such action. The department disagrees that a signed receipt for certified mail can be deemed to be the employee's acknowledgment. The acknowledgment form contains certain information that must be provided to the employee and also requires the employee to provide certain information on the form, such as where the employee lives. A receipt for certified mail does not meet this standard. Neither an employer nor a carrier is precluded from establishing a standardized process for delivery of the notice to include the use of certified or return receipt mail, but such process does not satisfy the requirement that signed acknowledgment forms be collected and maintained. Adopted §10.60 clarifies that when a carrier has an obligation to deliver the notice of network requirements and obtain the signed acknowledgment form, the carrier must also comply with the requirements of §10.60(c) - (h), as applicable.

§10.60: A commenter requests that the rules be changed to state that the carrier can delegate to the network the duty to deliver the notice through a network-carrier contract based upon provisions that require carriers to provide the notice. The commenter asserts that networks will be active participants in the development of the notice, so the process will be more efficient if the networks deliver the notice to participating employees.

Agency Response: Under Insurance Code §1305.005 the employer is generally the party responsible for delivering the notice of network requirements to employees, including all the information required by §1305.451, and that it is the employer who is required to obtain a signed acknowledgment form from each employee, except in certain specified instances. Therefore, the department declines to make the requested change. In those circumstances when a carrier may deliver the notice, such as in the event of the employer's failure to deliver the notice or in circumstances where the carrier is required to deliver the notice, such an employee who is injured prior to the effective date of the Act, or prior to the employer's electing a network-limited plan, the carrier may delegate delivery requirements to a network. In such instances, the notice and mailing must clearly indicate that the notice is from the carrier and not the network.

§10.60: A commenter asserts that there are situations under the new workers' compensation law when a carrier, rather than an employer, is required to deliver the notice to employees. Insurance Code §1305.103(c) requires the carrier to provide notice to employees that are injured before the date that the carrier established or contracted with a network. Section 8.016 of the statute requires carriers to provide notice to employees injured before the effective date of the Act. The commenter recommends that §10.60 be amended to account for these scenarios.

Agency Response: The circumstances described in Insurance Code §1305.103(c) and §8.016 of HB 7 are addressed in the rule under §10.60(b). Section 10.60(b) applies to an employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with a network, which includes employees who were injured before the effective date of the Act as well as employees injured after the effective date of the Act but before the employer or carrier established or contracted with a network. This subsection also addresses the carrier's obligation to provide a notice of network requirements and an acknowledgment form to these employees. The department recognizes that a carrier required to provide notice to employees under Insurance Code §1305.103(c) should obtain the signed acknowledgment form provided to those employees. Accordingly, the department has added a provision to §10.60(f) to require carriers to obtain the employee acknowledgment form from these employees subject to Insurance Code §1305.103(c).

§10.60 and §10.60(g)(14): A commenter requests that the information regarding providers that is required to be given to employees should also be given in electronic format because it can be updated daily. The commenter suggests providing one copy of the directory to be available at the employer's site, with electronic access available to all employees though the internet. Other commenters state that the rule does not include language that addresses how the network's list of healthcare providers is to be provided to an employee, and suggests addition of new provisions requiring provider directories to be published on a website with paper copies available upon request.

Agency Response: The department has made changes to the proposed rule to address the commenter's concerns. The department has added a provision in §10.60(c) to allow carriers and employers to deliver notices of network requirements in an electronic format, so long as a paper version of the notice is available upon request. This provision does not change the requirement that provider directories be updated at least quarterly. Additionally, a new provision has been added to §10.60(f) to allow the acknowledgment of receipt through electronic means.

§10.60(a): A commenter opines that some differentiation should be made for the different requirement for time of notice in Insurance Code §1305.005(d),(e) and (g). Acknowledgement of prior notification should be sufficient for employee notice upon employer notice of an injury. In addition, the commenter believes that given that notice of injury may be given to the employer by a range of persons representing the employee, the rule should specify that network notice requirements may be provided to any person who may give notice to the employer of an injury on behalf of the injured employee. Another commenter recommends that §10.60(a) be modified to specify that a single acknowledgment is sufficient to bind employees to the network requirements. Another commenter asks that §10.60 be modified to permit the carrier to deliver the notice to staff leasing companies alone.

Agency Response: To avoid confusion regarding when an employee is to receive notice, the department has deleted references in §10.60(a) to the subsections (d), (e) and (g). With the deletion, the rule refers only to Insurance Code §1305.005, which requires that employees receive notice at the time of injury, as well as at other times. Notice to an employee at the time of injury is crucial and is specifically required by the statute. Therefore, network requirements are not applicable to an injured employee until notice is delivered to the injured employee by an employer that has received actual or constructive notice of the injury. Section 10.60(a) incorporates these provisions by reference. Any provisions in the Labor Code or related rules allowing any one of various persons representing the employee to give notice of injury to an employer would not override the Chapter 1305 requirements that the notice of network requirements be delivered to and the acknowledgment signed by the employee. In order to ensure that an injured employee has received notice of the network requirements, notice cannot be given to an entity such as a staff leasing company. While the notice may be delivered through the staff leasing company, the acknowledgment must come from the individual employee.

§10.60(a): A commenter requests that any one documented instance of refusal should suffice to trigger Insurance Code

§1305.005(f) and subject the refusing employee to the network requirements.

Agency Response: While the rules do not require multiple documented instances of refusal before subjecting the refusing employee to network requirements of the applicable network, it does not relieve the employer of its obligation to give a refusing employee a subsequent notice and a new acknowledgment form upon a change of insurance carrier or network.

§10.60(a)(1): A commenter strongly feels that the department should establish a specific time frame within which the employee is provided notice of network requirements. The commenter asserts that notice should be provided to the employee not more than one week or five working days after the date of employment. The commenter opines that setting a mandatory time line should significantly limit the number of employees who receive notice only after they are injured.

Agency Response: The department declines to add a specific time frame at this time because the rule incorporates by reference the statutory time frames. Section 10.60(a) requires carriers that establish or contract with networks to deliver to the employer, and the employer shall deliver to employees in the manner and at the times prescribed by Insurance Code §1305.005. Insurance Code §1305.005(d) does not set forth any time frames for initial notice following establishment of the network. Subsection (e) requires employers to provide to employees hired after the notice is given under subsection (d) the required notice and information not later than the third day after the date of hire. Subsection (g) requires the employer to notify injured employees of the network requirements at the time the employer receives actual or constructive notice of an injury. Regarding concerns that the notice may not be provided timely, under the statute, an injured employee is entitled to seek care from any out-of-network providers prior to receipt of the notice.

§10.60(d): A commenter supports the creation of a sample acknowledgement form as referenced in §10.60(d) and requests the opportunity to submit input on the development and content of this standardized acknowledgement.

Agency Response: The commenter's support is appreciated, and the department has developed a sample acknowledgment form that will be available on its website. Pursuant to §10.60(d), a carrier and employer may use the sample acknowledgment form or the carrier and employer may develop and file an acknowledgment form that complies with the requirements of §10.60(c) - (e).

§10.60(e) and §10.60(e)(2)(C): A commenter requests that §10.60 be revised to fairly notify employees, in both the notice and acknowledgment form, of all the circumstances when they may be liable for care. A commenter requests that the rule be revised to state that the employee may be liable for in-network care provided without a proper referral from a treating doctor because §10.60(e)(2)(C) only requires that the acknowledgment form notify an employee that the employee may be responsible for out-of-network care provided without network approval.

Agency Response: The department declines to make the suggested changes because the notice requirements in §10.60 incorporate all the circumstances when employees may be liable for care. Also, the hold harmless provision at Insurance Code §1305.152(c)(1) and §1305.451(b)(6) does not specifically carve out the circumstance of the employee liability for in-network care provided without a proper referral from a treating doctor from its application. §10.60(e)(2)(A) and §10.85(d): A commenter requests that the rules detail how carriers are to verify that an HMO provider is the injured workers' primary care physician.

Agency Response: It is the position of the department that carriers should be free to determine what method best suits their needs, and therefore, the department prefers not to prescribe how a network obtains such proof. The various methods by which a network could obtain proof that an HMO provider is the injured workers' primary care physician include HMO ID Cards, employee contact information, or employer verification.

§10.60(e)(2)(A)(iii): A commenter asks what defines an emergency and states that there must be a mechanism that the network or the employer must be contacted before the employee shows up at the emergency room on a weekend or after hours or anytime to avoid denial of charges.

Agency Response: The term "emergency" is defined pursuant to statute. Section 1305.004(a)(7) defines "emergency;" subsection (a)(13) defines "medical emergency;" and subsection (a)(15) defines "mental health emergency." Sections 10.2(a)(7), (15) and (17) of the rule incorporate these definitions by reference. Section 10.102(a) provides that carriers and networks that use preauthorization processes within a network are to follow the requirements of Insurance Code §§1305.351 - 1305.355. Section 1305.351(c) states that "a network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency." Additionally, §1305.006 provides that an insurance carrier that establishes or contracts with a network is liable for out-of-network emergency care that is provided to an employee.

§10.60(f): A commenter asserts that insurance carriers and networks should be authorized to accept acknowledgment of notice requirements by electronic means and that requiring a signed, paper acknowledgment is unnecessary and wasteful. Another commenter requests that the rules clarify that an electronic signature would satisfy the requirement for employee signature on the acknowledgment form.

Agency Response: The department agrees and has made changes to the proposed rule to address the commenters' concerns. The department has added a provision to §10.60(f) to clarify that acknowledgment of notice requirements may be accepted by electronic signature and by electronic means. The department understands the need to avoid waste. Even without the change, the rule would not prevent an employer or carrier from scanning or otherwise imaging copies of the signed acknowledgment forms and storing legible scanned or imaged copies by electronic, retrievable means.

§10.60(g): A commenter proposes a new paragraph to provide a transition period wherein certain employees who are already receiving treatment could continue treatment with a non-network provider for a period of time not to exceed one year. Such transition period would apply only to employees with an acute condition, a serious, chronic condition including chronic pain, a terminal illness, and to employees with authorized surgery or other procedure that is scheduled to occur within the next 180 days.

Agency Response: The department does not have the authority to make the requested change as it is contrary to statute. Insurance Code §1305.103(c) states that an employee who lives in the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, must select a network treating doctor upon notification by the carrier that health care services are being provided through

the network. If the employee does not select a network treating doctor within 14 days after receiving a notice of network requirements, the network will assign the employee a treating doctor. Workers' compensation health care networks are required to provide comprehensive and medically necessary care to treat a compensable injury. If a treatment or service is determined to be medically necessary, it must be provided. The statute provides no exceptions to this requirement.

§10.60(g): Another commenter also proposes a new paragraph in §10.60(g) to include a statement that the network must ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and that the division shall periodically examine whether reasonable access exists.

Agency Response: The department declines to make the suggested change because the department does not agree that it is necessary to specify certain treatments or services that must be available, as all medically necessary care must be delivered to an injured employee.

§10.60(g)(6): A commenter requests clarification regarding who is going to be a treating doctor and why it appears that specialists such as orthopedic surgeons will not be treating doctors and will have to obtain referrals for visits.

Agency Response: Insurance Code §1305.103(a) provides that a network shall determine the specialty or specialties of doctors who may serve as treating doctors. Neither the rule nor Chapter 1305 prohibits networks from designating orthopedic surgeons as treating doctors or from designating them as both treating doctors and specialists in their provider directory.

§10.60(g): A commenter requests that the notice provisions set forth in §10.60(g)(5) - (8) be changed to more definitely establish that an employee will be liable for health care services in those circumstances. Additionally, the commenter requests a new paragraph (9) that would reference an employee's potential liability for health care services if the employee commits fraud in reference to the employee's address.

Agency Response: The department has changed the proposed rule in §10.60(g)(5) to address an employee's potential liability when the employee is found to live inside a network service area but to have received out-of-network services during the pendency of a dispute regarding where the employee lives. The department declines to make the other requested changes because it appears that the commenter is attempting to establish clear liability, when many other issues may also affect which party is ultimately liable.

§10.60(g) and §10.80(c): A commenter states that "specialist" as opposed to "treating doctor" may warrant definition because the rules allow the network to arrange for services including the referral to "specialists" while the worker may choose a treating doctor from the network's treating doctor list. The commenter asserts that "specialist" and "specialty" are terms used in a number of other contexts in the proposals and might generate confusion or disputes if not given the proper definition for the specific context.

Agency Response: The department does not agree that the term "specialist" needs to be defined and declines to make the suggested change. Generally, specialists are those other than treating doctors to whom treating doctors make referrals.

§10.60(g)(3): A commenter asserts that this provision requires that the employee be given detailed maps of the service area, including specified information contained in the subsection. The commenter states that this will result in bulky, difficult to read information that is expensive to produce and of limited value to employees and that this requirement should be deleted.

Agency Response: Employees need to be provided with maps of the area where they live, but there is no requirement that employees receive a map that is applicable only to areas outside of the area in which the employee lives. Therefore, limiting maps to a particular region may be appropriate. However, larger maps describing the entire service area must be available upon request. Additionally, employees are not subject to network requirements for regions not included in the notice.

§10.60(g)(4): A commenter opines that the department should establish a requirement that employees are provided notice of all pertinent information necessary for those who do not live within the network's service area.

Agency Response: The department does not agree that an additional notice requirement beyond those included in the statute is needed at this time but will monitor the issue and assess any need for future notice requirements. The adopted rules ensure that all employees receive notice of the network requirements, which will allow an employee living outside the service area to understand that the requirements are inapplicable.

§10.60(g)(5) and §10.62(e): Commenters recommend that the rule require employees asserting that they live outside the service area to receive all care from network providers during the pendency of the insurance carrier's review of the employee's assertion or the department's review of the insurance carrier's decision. Another commenter suggests the same revision but would add that the rule should also expressly state that the employee will be liable for the care received out-of-network during the pendency of the appeal unless it is ultimately established that the employee lives outside the service area.

Agency Response: The department declines to make these changes because the presumption is that the employee is telling the truth about where the employee lives, and the truthful employee would be penalized by the requirement that this change would impose. Additionally, the suggested change could penalize employees who are unable to travel into the service area for treatment due to their injuries or those injured employees who require out-of-network care while living outside the network service area, such as those who require assistance with daily activities from caregivers. Additionally, the suggested changes are not consistent with Insurance Code §1305.451(b)(6), which provides that if the employee obtains health care from non-network providers without network approval, except as provided in §1305.006, the carrier may not be liable and the employee may be liable for payment for that health care.

§10.60(g)(5): A commenter states that §10.60(g) should be revised to fairly notify employees of all instances in which they may be liable for in-network or out-of-network care.

Agency Response: The statute and the rule address all contingencies of when an employee may be liable for in-network or out-of-network care. Insurance Code §1305.152(c)(1) and §1305.154(c)(4), as well as §10.42(b)(1) of the rule, require provider contracts and subcontracts to include at a minimum a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Insurance Code

§1305.451(b)(6). Section 1305.451(b)(6) provides the only exception (when employee obtains health care from non-network providers without network approval, except as provided by §1305.006). The department has changed the proposed rule in §10.60(g)(5) to address an employee's potential liability when the employee is found to live inside a network service area but to have received out-of-network services during the pendency of a dispute regarding where the employee lives.

§10.60(g)(7): A commenter recommends removing "network or" because networks do not pay workers' compensation medical bills.

Agency Response: The department declines to make the suggested change because there is a statutory basis for this language. Insurance Code §1305.152(c)(1) requires provider contracts and subcontracts to include a hold harmless clause stating that the network and network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by §1305.451(b)(6).

§10.60(g)(7): Commenters state that §10.60(g)(7) requires that the notice advise an employee of the "hold-harmless" protections and indicate that the employee will not be liable for any in-network care. Commenters respectfully request that the language be revised to clarify that the employee may be liable for payment for in-network healthcare services, if the employee did not follow the network requirements and obtain care either from the designated treating doctor or from a specialist, with appropriate referrals from the employee's treating doctor.

Agency Response: The department does not have the authority to make the requested revision. The statute is very resolute. Insurance Code §1305.152(c)(1) and §1305.154(c)(4), as well as §10.42(b)(1) of the rule, require provider contracts and subcontracts to include at a minimum a hold harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Insurance Code §1305.451(b)(6). Section 1305.451(b)(6) provides the only exception (when employee obtains health care from non-network providers without network approval, except as provided by §1305.006).

§10.60(g)(12)(B): A commenter expresses an opinion that the deadline for filing complaints should be no less than 180 days after the date of the event or occurrence. If the complaint is regarding a utilization review, then, by definition, the time to get an independent review organization decision may be more than the 90 days.

Agency Response: Insurance Code Chapter 1305 and the rule do not establish a deadline for filing complaints. Insurance Code §1305.401(b) allows the network the option to set a 90-day deadline for filing complaints beginning with the date of the event or occurrence that is the basis for the complaint. Therefore, the network may elect to set a longer time period for the deadline. Section 10.60(g)(12)(B) requires that the notice of network requirements disclose whether the network has opted to establish a deadline. In addition, the statutory definition of complaint states at Insurance Code §1305.004(a)(5)(B) that a complaint does not include an oral or written expression of dissatisfaction or disagreement with an adverse determination. Utilization review complaint and appeal deadlines are addressed in Subchapter F of the rule.

§10.60(g)(12)(C): A commenter states that a single point of contact within the network is good in concept, but there must be a backup system when this point of contact is not available.

Agency Response: The department does not agree because the single point of contact may be a customer service unit or other unit, so that there would be more than one person involved in handling the complaint intake process.

§10.60(g)(14): A commenter requests that the section be amended to require the network to update its list of contract providers every 30 days for web-based listings and every 90 days for print based listings.

Agency Response: The department declines to make the suggested change because the rule mirrors the statutory language in Insurance Code §1305.451(b)(12). However, if the network chooses, it can update the provider lists more often.

§10.60(g)(14): A commenter states that given that most employees will not incur a compensable injury, the at-least quarterly requirement must not be construed so as to require that every employee receive a quarterly directory, which would be cost prohibitive. The commenter suggests that language should indicate that every employee have access to a list through their employer or through a website.

Agency Response: The rule does not require that employees be given a provider directory quarterly. Section 10.60(a) provides that an insurance carrier that establishes or contracts with a network shall deliver to the employer, and the employer shall deliver to the employer's employees in the manner and at the times prescribed by Insurance Code §1305.005 a notice of network requirements and employee information which includes the provider directory that is a current directory. A provider directory is current if it is updated at least quarterly. Section 1305.005(g) requires notice at the time the employer receives actual or constructive notice of an injury. Section 1305.005(d) requires employers give all employees the notice of network requirements and to post notice of network requirements at each place of employment. Section 1305.005(e) requires notice at the time the employee is hired.

§10.60(g)(14)(A): Commenters recommend deleting the requirement in §10.60(g)(14) that the list of network providers included in the notice must clearly identify the providers who are authorized to assess maximum medical improvement and render impairment ratings. The commenters state that this requirement is unnecessary because treating doctors sometimes refer patients out of network for assessments, and the employee will not understand the terminology and the assessments will occur whether or not the authorized providers are identified.

Agency Response: The department declines to make the requested change because the information is needed for other purposes. The information contained in the provider directory is also needed by network doctors who may wish to refer their patient to a network provider to assess maximum medical improvement (MMI) and impairment ratings (IR).

§10.60(g)(14)(A): A commenter requests that, to assure consistency within the system, the department define the term "treating doctor" and show the criteria used to draft the definition.

Agency Response: The term "treating doctor" is defined in the rule. Section 10.2(b)(13) and Insurance Code §1305.004(b)(10)

incorporate the definition of "treating doctor" by reference to Labor Code §401.011(42), which defines "treating doctor" as "the doctor who is primarily responsible for the employee's health care for an injury." Because the definition is a statutory definition, the department does have information on the criteria used to write the definition.

§10.60(g)(14)(A): A commenter states that it would be advantageous for a network to have the flexibility to list the same doctor on both the treating doctor list and the specialist doctor list and requests that the rule be revised to reflect such.

Agency Response: The networks have the flexibility to list the same doctor on both the treating doctor list and the specialist doctor list if the doctor indeed meets both descriptions under the current rule language.

§10.60(g)(15): A commenter asserts that allowing 21 days for a network to arrange for services including referrals to specialists, is too much time for an injured employee and requests that the time be limited to 72 hours. The commenter states that 21 days is too long to wait to get an injured worker treatment. The commenter asserts that to reduce medical costs, getting the injured worker to the providers quickly and back to work quickly should be the focus and that this time period should be 5 - 10 days maximum. Another commenter feels that referrals to specialists should not be denied. The commenter indicates that certain conditions, when left untreated, become chronic and potentially permanent. The commenter asserts that the initial visit, at a minimum, should be allowed and paid for; however, subsequent visits should be subject to preauthorization. A commenter feels 21 days is too long to wait for referral to specialists and such delay could increase the amount of needed care (e.g., necessitate additional surgery).

Agency Response: Under Insurance Code §1305.302(f), the statutory requirement for referrals for care (except emergencies) is: "... to be accessible to employees on a timely basis on request, but not later than the last day of the third week after the date of the request." Although the rule currently mirrors the statute, the department recognizes that circumstances may sometimes warrant services being provided sooner. Therefore, the department has changed the provision to clarify that the referral should be made within the time appropriate to the circumstances and condition of the injured employee but not later than 21 days after the date of the request. Under the statute, a treating doctor's referrals to an in-network specialist do not require approval by the network. Although out-of-network referrals require approval by the network, they must be allowed where appropriate. It is the department's position that when circumstances warrant, care must be provided quickly, and that should guide the network in its referral process.

§10.60(h): A commenter states that §10.60(h) requires employers to deliver a notice and acknowledgement for a "network that has a service area in which the employee lives." A commenter asserts that it is unclear how to determine if the employer has sent the appropriate network notice. The commenter notes that §10.60(h) provides that failure of an employer to establish a standardized process for delivering the notice creates a rebuttable presumption that the employee has not received the notice. The commenter states that this should be reversed to state that if an employer establishes a standardized process, documentation of that process should create a rebuttable presumption that notice was received. Another commenter also requests deletion of the phrase "for a network that has a service area in which the employee lives" because the responsibility of the employer is to ensure that the notice is delivered and that the service area be identified; the employee's residence is secondary in this situation.

Another commenter states that there is no requirement in Insurance Code Chapter 1305 that the employer establish a "standardized process of delivery." As long as there is credible documentation that the employer (or carrier) delivered notice of the network requirements to the employee then the employee should be subject to the network requirements. Otherwise, there will be cases in which the Division could rule that an employee is not required to get medical care within the network despite the fact that the employee was notified of the network requirements on the grounds that the employer had failed to "establish a standardized process of delivery." The commenter posits that this could lead to many disputes in which notified employees try to escape network coverage by challenging whether or not the employer has an established standard process of delivery.

Agency Response: The department declines to make the suggested change because the requested change appears to subject an employee to network requirements even though a notice for the appropriate network was not actually provided. In addition, the consequence of failing to establish a standardized process will prompt an employer to establish such a process. The rules do not require an employer to establish a standardized process of delivery. An employer's or carrier's failure to establish a standardized process as set forth in §10.60(h) creates a rebuttable presumption that the notice was not received by the employee. The department has changed §10.60(h) to require documentation of the location of delivery, method of delivery, and to whom the notice was delivered.

§10.60(h): A commenter states that the rule offers inadequate protections to carriers if employers are lax in distributing the notice of network requirements. The commenter recommends revising §10.60(h) to require that employers deliver the notice and acknowledgment form to employees within 5 - 7 business days of signing the network plan contract or at least 30 days prior to the effective date of coverage and for new employees within two business days after their first date of employment.

Agency Response: The department declines to make the requested change. Section 1305.005(d) states that the insurance carrier shall provide the notice to the employer for delivery to employees but does not impose a time requirement on either party. The department declines to impose such a requirement on an employer without express statutory direction. In addition the department does not have the authority to require that notice to new employees be delivered within two business days of the first date of employment because §1305.005(e) requires notice delivery to new employees no later than the third day after the date of hire. It appears that an employer would have an interest in delivering the notice promptly in order to reduce the employer's cost-of-claim experience.

§10.60(h): A commenter requests that §10.60(h) be revised to state that if the employer fails to deliver or to maintain documentation of delivery of the notice of network requirements, the carrier has the right to adjust the employer's premium to reflect the fact that some or all of the employees will not be subject to previously agreed upon network requirements.

Agency Response: The department declines to make the change. If the carrier's policy or any endorsements to the policy call for a premium adjustment under these circumstances, the rules would not prohibit the carrier from adjusting the employer's

premium. Also, if a contracting party has not performed as agreed to the detriment of the other contracting party, there may be other avenues available for the damaged party to seek redress. This includes delivery of notices by the carrier if the employer fails to do so.

§10.60(h): A commenter observes that the rule does not state whether the employee must live in the service area at the time the notice is delivered and recorded or at the time the employee is injured in order for it to be assumed whether the notice is delivered.

Agency Response: An employer must deliver a notice that applies to the employee's address in order for the network requirement to apply to the employee. This will be most important at the time of injury, as the injured employee should be given notice that is specific to the employee's address at the time of the injury.

§10.60(i): A commenter states that Labor Code §408.0271 requires carriers to notify only health care providers within a network of a non-compensability determination. The commenter suggests a change to include in the rule a method for a pharmacy to check on the status of a patient's claim for services. Such pharmacy access could be through a secure online website or telephone conference. According to the commenter, notice must be made available to pharmacists within a reasonable time period. The commenter recommends that the carrier be liable for all pharmacy services provided until the notice was made available to pharmacies. The commenter proposes that pharmacies be responsible for checking an injured employee's compensability status and for services provided after the date the notice was made available.

Agency Response: Insurance Code §1305.101(c) provides that prescription medication or services may not be delivered through a workers' compensation health care network but shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation. Therefore, the proposed rule does not address the concept of notice being given to non-network pharmacists. The department will monitor this issue for possible future rulemaking.

§10.61: A commenter requests a definition for "network service area" because the lack of a definition allows the opportunity for abuse of the system.

Agency Response: The rule and Insurance Code §1305.004(a)(24) define service area as a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

§10.61(e): Several commenters recommend that, if an employee has committed fraud, the language "may be liable for payment for that health care" be changed to "will be liable ...." to send a very clear message that fraud will not be tolerated and that there are consequences for doing so. The commenters state that failure to do so may create problems. Another commenter states that providers who give healthcare treatment and services to injured employees who have fraudulently misrepresented where they live should not be unfairly penalized by a law with no teeth. Another commenter requests amendment by adding that, at the insurance carrier's discretion, the employee shall be liable for payment of the difference between what the carrier paid to the non-network provider and what the insurance carrier would have paid for the same service if a network provider had rendered it.

Agency Response: The department declines to make the specific change to add language stating that the employee "will be liable" because the employees' liability turns on a number of contingencies such as being able to prove an injured employee "fraudulently claimed to live outside the network's service area. . . ." The department agrees that fraud should not be tolerated. However, the requested change does not necessarily provide an effective countermeasure to possible fraud, but does attempt to add a conclusory statement regarding liability to the rule. The department declines to make the requested change concerning the insurance carrier's option to charge a balance to the employee as it could encourage or provide an out-of-network option for employees that is not contemplated by the statute.

§10.61(f): A commenter supports §10.61(f), which clarifies a carrier's liability for payment of out-of-network services and the available remedies if a network denies a referral request. However, the commenter recommends that the department adopt a definition for "emergency care." Although the proposed rules define "emergency" as "either a medical or mental health emergency," these definitions do not address the scope of services that constitute "emergency care," nor do they adopt the prudent layperson standard applicable to HMOs. Because workers' compensation health care networks closely resemble HMO products, the commenter suggests the inclusion of the definition "emergency care" for HMOs set forth in Texas Insurance Code §843.002(7).

Agency Response: The department declines to make the recommended change because the definition of "medical emergency" in §10.2(a)(15), which mirrors the language in the statute at Insurance Code §1305.004(15), is sufficient.

§10.61(f): A commenter raises concerns that the rules do not address the possibility that a network doctor may not be available at the time of injury, whether because the network has lost or failed to add a sufficient number of providers or because a network doctor who treats the specific injury is not taking new patients. If networks are to be designed so that employees receive adequate care and are able to return to work as soon as possible, the commenter believes the rules should specify that employees may receive care from out-of-network doctors if no network doctor is available. The commenter maintains that although the department presumably would take administrative action against the network, the injured employee could require more immediate medical care, including out-of-network care. The commenter recommends adding language that specifically provides for an employee's ability to go to an out-of-network provider in such a circumstance.

Agency Response: The department declines to make the change. Networks are required to have adequate numbers of treating providers available to injured employees. If a significant number of providers leave the network, the network is required to notify the department through a modification of network configuration filing under §10.27. The department will then be able to require that necessary providers be available whether through a filed access plan or some other similar mechanism. As far as the availability of a specific network provider, treating doctors are required to have coverage 24 hours a day seven days a week. In some situations, such as if a doctor is on vacation the doctor may make arrangements for another doctor to substitute as necessary. If a doctor leaves a network, the employee will need to choose another treating doctor.

§10.61(f)(2): A commenter expresses concerns with the provision that specifies that an insurance carrier is liable for "health-

care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract." The commenter is concerned with the inclusion of the word "any" before network and the commenter states that the rules need to specify that the network established by the insurance carrier must be that which has been contracted for by that employee's employer. According to the commenter, that is the only way that the notice requirements can be met by the employer and the carrier as well; this could present a potential conflict if not clarified before final adoption.

Agency Response: This provision tracks the language in Insurance Code §1305.006(2), which states that carriers are liable for out-of-network health care that is provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract. This language does not require that an employer deliver notice of a network or service area for which the employer did not contract. Additionally, an employee is not liable for out-of-network health care if the employee has not received an appropriate notice of network requirements in accordance with §1305.005 that is applicable to the network for which the employer has contracted and the area in which the employee lives.

§10.61(f)(3)(A): One commenter recommends that this section be changed to provide that a network must approve or deny a referral by a network treating doctor to an out-of-network provider "for medically necessary services that are not available from network providers" within not more than three days rather than the seven days provided in the rule. The commenter believes that seven days is too long a period to address such a referral.

Agency Response: The department agrees that seven days may be too long to wait for a referral in some instances. Accordingly, the language in §10.61(f)(3)(A) requires the network to approve or deny a referral to an out of network provider "within the time appropriate under the circumstances but, under any circumstances, not later than seven days after the date the referral is requested."

§10.61(f)(4): A commenter requests that §10.61(f)(4) be revised to delete "appropriate" and reference only subsection (a) of §10.60.

Agency Response: The department declines to make the suggested change to delete the word "appropriate." Section 10.61(f)(4) addresses the employee who received a notice of network requirements that does not apply to the service area where the employee lives. The carrier is responsible for care provided before the employee receives the notice of network requirement for the appropriate network and service area. The department has made a clarifying change to proposed §10.61(f)(4) by adding "and service area" after "appropriate network" to further clarify that an employee must receive a notice that specifically applies to the employee and where the employee lives. Regarding the suggestion that subsection (a) be added to the reference in the provision to §10.60, the department declines to add this specific reference because the duty to deliver the notice to previously injured employees is addressed in subsection (b) of that section.

§10.62: A commenter observes that the dispute resolution process is pretty successful in commercial health and thinks that the networks are reporting all their dispute resolutions and outcomes as required. The commenter suggests that the department should monitor how the dispute resolutions are working.

Agency Response: The department appreciates the comment. The department currently monitors the dispute resolution processes for HMOs on a routine basis, and for other types of carriers on a case-by-case basis.

§10.62: A commenter states that the proposed rule does not require the employee's request for review to be in writing, although it does require the injured employee to provide the insurance carrier with supporting evidence. The commenter recommends that the rule be amended to provide that an employee must submit its request to the insurance carrier in writing and that the request must be accompanied by evidence that supports the employee's assertion.

Agency Response: The department declines to make the proposed change because an employee may not be able to make a written request for review. Also, the commenter's concern is addressed by the fact that the additional evidence submitted to the carrier will provide documentation of the request.

§10.62: A commenter requests that the department ensure that hospitals not be penalized in the event of a dispute over where the employee lives.

Agency Response: The rules contemplate that all providers are similarly situated and will be similarly affected in the event of a dispute regarding where an employee lives. The department has modified the contents of notice of network requirements in §10.60(g)(5) to include notice to an employee at time of injury that the employee may be liable for out-of-network care received during the pendency of a dispute regarding where the employee lives. The department does not have the authority to ensure by rule that hospitals are not penalized in the event of a dispute over where an employee lives. A hospital may take needed measures to ensure that the hospital gets paid in accordance with federal and state law.

§10.62(b): A commenter states that the alternative service area provision is double jeopardy because the carrier can issue a service area map, determining in and outside the network service area, but still require an employee to participate in an alternate network. According to the commenter, employees should not be subject to an alternate service area.

Agency Response: The requirement to participate in an alternate service area is based on the statutory requirement in Insurance Code §1305.006, which provides that the carrier is responsible for health care provided to an injured employee who does not live within the service area of any network established by or contracted with the insurance carrier. Any and all networks and service areas may be considered to determine whether the employee lives in a network's service area, but network requirements will not apply until the employee receives the appropriate notice that applies to the correct network or service area. An employee may not be held liable for care received outside the alternate network unless the employee has received notice of network requirements for the alternate network.

§10.62(b): One commenter opines that in some cases, it may be acceptable and preferable for an employee to receive services within an alternate service area, but the rule should take into account whether the employer has contracted with the carrier for the alternate service area. According to the commenter, a carrier should not be required in every instance to allow employees to access alternate service areas of the network. Accordingly, the

commenter requests that this rule be revised to provide that the employee may receive services in the alternate service area if the carrier and the employee agree to this arrangement, which is consistent with §10.61(d).

Agency Response: The department declines to make the requested change because the ability to access an alternate service area will depend upon the language in the contract issued to the employer. If the employer purchased access to a network that includes more than one service area, then more than one service area will be available. If the employer did not purchase access to any and all of a particular network's service areas, that will control the determination of whether an alternate service area applies.

§10.62(b): A commenter asserts that the proposed rules are unclear and seem to conflict with regard to employees who are temporarily or permanently outside the original network's service area but within a service area of another network established by or contracted with the applicable carrier. The commenter states that §10.62(b) indicates that an alternate service area employee is required to receive services within the alternate service area of a network contracted with or established by the carrier upon receipt of a notice from the carrier by selecting a treating doctor in the alternate service area. The commenter opines that §10.61(d) suggests that an alternate service area employee may choose to receive services within the alternate service area of a network contracted with or established by the carrier by stating that an employee who does not live within the original network's service area "may choose to participate" in a "network established by the insurance carrier or with which the insurance carrier has a contract." Carriers, however, are not generally liable for out-of-network care provided to alternate service area employees (excepting emergency care and necessary referrals). Under §10.61(f)), which tracks Insurance Code §1305.006, the commenter believes that a carrier is only liable for out-of-network care provided to employees who live outside the "service area of any network" established by or contracted with the carrier. Because alternate service area employees do live within a service area of a network established by or contracted with the carrier, the commenter asserts that the carrier's liability seems to be limited to "in-network" care for alternate service area employees (although in this context, "in-network" would arguably include providers in the service area of the original network or the alternate service area in which the alternate service area employee lives).

Agency Response: Network requirements do not apply to a particular employee if: (1) the employee lives outside the service area; or (2) the employee has not received appropriate notice of the applicable network. An employee who does not live within a network service area may seek out-of-network care. This is true without regard to the circumstances that establish where the employee lives (e.g., temporary assignment, travel). Similarly, an employee who has received the appropriate notice of network requirements must generally seek services inside the network. This is also true without regard for an employee's individual circumstances that may affect where the employee lives. The basic requirement of the rules and statute is that the employee must receive notice of any network that a carrier wishes to apply to the employee.

§10.62(c): A commenter states that the proposed rule requires the insurance carrier to notify the employee, in writing, of the carrier's determination no later than seven calendar days after the date the insurance carrier receives notice of the employee's request for review. The commenter indicates that seven calendar days is not an adequate amount of time. Commenters request that the proposed rule be amended to provide that an insurance carrier must notify the employee, in writing, of the carrier's determination within ten business days of receiving the employee's request for review.

Agency Response: The department declines to make the requested change because the department believes that seven calendar days is a sufficient amount of time for a carrier to review the employee's evidence and make its determination. It is important that all injured employees have timely access to health care services. An injured employee who asserts that he or she does not live in the network service area is entitled to a prompt resolution of the dispute so the employee will know if out-of-network care will be covered.

§10.62(e): A commenter states that if an employee disputes whether he or she lives within the network and that employee is driving to and from a network area every day, it is not overly burdensome if the employee disputes whether the employee lives within the network to require them to receive their care in the network until that dispute is cleared up.

Agency Response: Section 10.62(e) permits an employee who disputes whether he or she lives within a network's service area to seek all care from the network during the pendency of the carrier's review and the department's investigation of a complaint. The department declines to make this change because the presumption is that the employee is telling the truth about where he or she lives, and the truthful employee would be penalized by the requirement that this change would impose. Additionally, the suggested change could penalize the employee who is unable to travel into the service area for treatment due to his or her injuries or those injured employees who require out-of-network care while living outside the network service area, such as those who require assistance with daily activities from caregivers. The department has changed the proposed rule in §10.60(g)(5) to provide that an employee who is receiving care from out-of-network providers during the dispute process may be liable for payment for health care services received out of network if it is ultimately determined that the employee lives in the network's service area.

§10.63(b): A commenter requests clarification as to whether this certification must be submitted only with the copies of the notice of network requirements and employee information forms that are filed with the department for approval or whether the certification must be distributed to every employee enrolled in a network plan. Given the content of the certification, a commenter encourages the department to require filing of the certification with the department only.

Agency Response: The department agrees that clarification is needed and has changed the proposed rule to clarify that the certification must be filed with the department.

§10.80: A commenter recommends that a new subsection be added to establish minimum acceptable standards for in-network utilization in a service area. The commenter states that minimum acceptable standards could be established using historical patient encounter data and that failure by a network to meet these acceptable standards of network utilization should result in the mandatory submission of a corrective plan of action for that area. The commenter also recommends that if a network continues to fall below acceptable utilization standards for a six month period, the network should be required to pay prevailing charges

for the delivery of all out-of-network services. Finally, the commenter proposes that continued failure to meet acceptable utilization standards should result in termination of the network in that service area by the department.

Agency Response: The department declines to revise the proposed rule to add the suggested requirements. Such revisions would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require the republication of the rule with another 30-day comment period before the rule could the considered for adoption. The department will monitor the issue for possible future rulemaking.

§10.80(a): A commenter commends the requirement that all services specified by §10.80(a) must be provided by a provider who holds a current appropriate license.

Agency Response: The department appreciates the support.

§10.80(b): One commenter opines that services billed as physical or occupational therapy must be provided by therapists licensed by the State of Texas and that chiropractic services should not be billed as occupational or physical therapy. If therapy is provided by a non-licensed occupational or physical therapist, the commenter urges that it be coded differently so that separate studies on cost and outcomes can be made by the network.

Agency Response: Insurance Code §1305.153(d) requires that billing by contracted providers will be subject to the requirements of the Texas Workers' Compensation Act and applicable rules as consistent with this chapter. Insurance Code §1305.302(a) requires that all services specified in the section be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements. Insurance Code §1305.302(d) requires that physical and occupational therapy services and chiropractic services be available and accessible within the network's service area. The Texas Workers' Compensation Act under Labor Code §413.011(a) requires that reimbursement procedures must be in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements. Therefore, the department anticipates that billing codes utilized by providers will be consistent with those requirements.

§10.80(b): Commenters request clarification of what will constitute an adequate network and what is a sufficient number of providers. Another commenter requests that the same criterion, ratio of providers to population, be applied to all health care providers and that all criteria be standardized by the department. The commenter further requests that the department set the ratio of providers to population to assure that providers are available and accessible to injured workers 24 hours a day, seven days a week, within the networks' service area, as stated in the rule.

Agency Response: The department will use historical utilization data and demographics to evaluate the network adequacy of applicants. As networks begin to provide care, the department will monitor complaints received by the network and through the department, as well as quality improvement studies by networks, to evaluate network adequacy on an on-going basis. The department declines to impose a more rigid standard which fails to promote flexibility to consider the discrete requirements of a particular service area.

§10.80(b): Commenters request clarification in the rule or in the preamble to the adoption of the rules that the rule and the statute do not require that all of the treating doctors and specialists in the network be available 24 hours per day and seven days per week, but that rather an adequate number of treating doctors and specialists from the network provider panel need to be available to render care 24 hours per day and seven days per week. Commenters suggest that the rule be modified to indicate that access to an urgent care or emergency care center during the treating doctor's and network specialists' non-business hours and days satisfies the accessibility requirement.

Agency Response: The department does not have the authority to make the requested change because §1305.302(b) requires that all treating doctors and specialists in the network be available 24 hours per day, seven days per week. Section 1305.302(b) provides that an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area. Availability may be established by telephone answering service, pager, or directly by telephone. The provider may direct employees to urgent care centers or emergency rooms if the provider judges such sites to be the appropriate location for care. Networks will be expected to monitor after-hours availability of providers as part of their quality improvement program and take action if providers are not available.

§10.80(b): Some commenters voice concern that there are no exceptions in the rule to address situations wherein a specific type of provider is unavailable and to allow for referrals to out of network providers.

Agency Response: Section 10.80(f) addresses situations wherein a specific type of provider is unavailable by requiring networks to include an access plan as set forth in Insurance Code §1305.302(h). Referrals to out-of-network providers are allowed. Insurance Code §1305.103(e) requires that a treating doctor provide health care to the employee for the employee's compensable injury and make referrals to other network providers, or request referrals to out-of-network providers, if medically necessary services are not available within the network.

§10.80(b)(2): A commenter suggests amending §10.80(b)(2) to require that the network's provider panel include sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees for all medically necessary covered treatments and therapies. The commenter also requests that a provision be added to require that, given the small subset of anesthesiologists and neurosurgeons that perform chronic pain implants, as well as the small group of neurosurgeons and orthopedic surgeons with specialization in spinal surgery, the network provider panel must include doctors who are qualified and willing to provide spinal surgery, which doctors are qualified and willing to provide chronic pain therapies, including but not limited to, the implantation of neurostimulators and intrathecal drug pumps that meet the access standards put forth in §10.80.

Agency Response: The department does not agree that the requested change is needed. If spinal surgery and chronic pain therapies such as implantation of neurostimulators and intrathecal drug pumps are determined to be reasonably necessary to treat injured workers, then they must be provided and the department expects that they will be provided. Pursuant to Labor Code §408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates by reference the definition of "health care" in Labor

Code §401.011(19), which specifies that a reasonable and necessary medical or surgical appliance is included in the term.

§10.80(b)(5) and (d): Commenters recommend decreasing the mileage limitations defining adequate accessibility because they believe that 30 miles and 75 miles are too far for injured workers, particularly physical and occupational therapy patients, to travel to receive care.

Agency Response: The department does not have the authority to change the distance requirements because they are statutorily mandated in Insurance Code §1305.302(g).

§10.80(b)(7): Commenters recommend changing §10.80(b)(7) to require only that the network's provider panel must include an adequate number of doctors, rather than treating doctors, who are qualified to provide maximum medical improvement and impairment rating services. One commenter states that there is no reason that maximum medical improvement and impairment rating services must be performed by a treating doctor and indicates that many ratings are done on a referral basis.

Agency Response: The department agrees that referral providers may provide maximum medical improvement and impairment rating services and has changed the rule accordingly.

§10.80(c): Commenters believe 21 days is too much time to get injured workers in to see providers.

Agency Response: Consistent with Insurance Code §1305.302(f), the rule requires a network to arrange for services, including referrals to specialists, to be accessible to injured employees within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 calendar days after the date of the original request. Section 10.80(c) contemplates that networks will arrange care according to timelines appropriate to the injured workers' circumstances and condition.

§§10.80, 10.22, 10.41, 10.42, and 10.60: A commenter states that the proposed rules address access to doctors and facilities but do not specifically address access to certain therapies such as those for chronic pain. The commenter requests that additional language be added to the rule that (i) requires reimbursement rates be sufficient to ensure reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues; (ii) indicates which doctors will implant neurostimulators and intrathecal drug pumps; (iii) requires a network to ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues; (iv) states that the Division shall periodically examine whether reasonable access exists; and (v) requires information concerning doctors who are qualified and willing to provide spinal surgery, and which doctors are qualified and willing to provide chronic pain therapies, including but not limited to, the implantation of neurostimulators and intrathecal drug pumps.

Agency Response: The department does not agree that the requested changes are needed. If spinal surgery and chronic pain therapies such as implantation of neurostimulators and intrathecal drug pumps are determined to be reasonably necessary to treat injured workers, then they must be provided and the department expects that they will be provided. Insurance Code §1305.103(e) requires that a treating doctor provide health care to the employee for the employee's compensable injury and make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Pursuant to Labor Code §408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates by reference the definition of "health care" in Labor Code §401.011(19), which specifies that a reasonable and necessary medical or surgical appliance is included in the term.

§10.80(g)(4)(C): A commenter states that §10.80(g)(4)(c) requires a network access plan to include a description of procedures to be followed by the network to assure that certain health care services are made available and accessible to employees in the geographic areas identified as being areas in which the health care services or providers are not available and accessible. If the services are unavailable or inaccessible, the commenter inquires as to what type of plan would assure availability and accessibility.

Agency Response: The network is required to show that it has sufficient contracted providers within its service area to provide comprehensive health care services to injured workers. The network is also required to identify areas in which it does not have adequate contracted providers and to submit an access plan for how it will provide the necessary services that are not available through contract. For example, an access plan may include a provision that employees may obtain service from a non-contracted provider. The department expects the network to indicate how the services will be provided to the employee.

§10.80(i): A commenter states that networks should be required to expand services outside the network's service area to accommodate employees who live outside the service area.

Agency Response: Insurance Code §1305.302(j) states that the network is not required to expand services outside the service area to accommodate employees who live outside the service area. However, the network may elect to obtain a contract with providers outside the service area for injured employees who live outside the service area due to temporary assignment or who are staying with a caretaker outside the services area in order to facilitate cost-effective care, if the employee agrees. Such an employee, however, may alternatively choose to seek care from non-network providers at his option.

§10.81: Commenters raise concerns about the lack of a requirement that networks coordinate their case management activities with the insurer and that case management efforts may be duplicated. Commenters also raise concerns about the over-utilization of case management and resulting unnecessary costs. A commenter requests a phase-in of the requirement that all case managers be certified provided a certified case manager supervises non-certified case managers to provide non-certified case managers with the opportunity to prepare for and take one of the bi-annual examinations. Another commenter states that credentialing raises the quality of the case manager to a higher standard and believes that there will be a resultant enhanced expertise to develop return-to-work planning and address the overall cost-effectiveness of evidence-based treatment outcomes. Another commenter suggests that there are several evidence-based guidelines which make reference to the delivery of case management triage under which each ICD-9 code condition uses algorithms applied to data to label each condition with priority indicators, which in turn help determine the appropriate level of case management required for the individual. The case management levels vary based on the severity of the injury, but, the commenter asserts that the timeframe from which an injury should be referred to case management should be carefully considered for optimum results. According to the commenter, by fol-

lowing these guidelines and establishing specific criteria within the networks for case management intervention, over-utilization of case management would be limited. Other commenters recommended specific certification requirements for inclusion in the rule.

Agency Response: Networks and carriers may agree by contract to procedures that will eliminate duplication of effort and ensure coordination between the case management programs of the two parties. The department agrees that a phase-in approach to achieving networks that have all of the case managers certified appropriately is beneficial and will allow non-certified case managers to take the necessary examinations. During the phase-in period, non-certified case managers must be supervised by certified case managers in order to assure the quality of the case management functions. The department has revised proposed §10.81 accordingly.

§10.81: A commenter states that the requirements related to quality improvement programs are too intense and believes the network should be able to delegate some of the requirements to the carrier.

Agency Response: The quality improvement requirements are derived from Insurance Code §1305.303. Networks may delegate credentialing to a qualified entity as set forth in Insurance Code §1305.102(c)(3) and §1305.154(c)(2) and (10).

§10.81: A commenter opines that the language of the rule should support that each major provider type is represented on the quality improvement committee.

Agency Response: The department recognizes that participation by a broad sample of providers on the quality improvement committee is a desirable goal. However, to add a requirement that each major provider type be represented on the committee would be a substantive change late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The department will monitor the issue for possible future rulemaking.

§10.81(a): A commenter asserts that quality improvement program procedures, processes and implementation should be available upon request pursuant to the Open Meetings Open Records Act and requests that a Doctor of Chiropractic should be appointed to each quality improvement committee.

Agency Response: Any requests to the department for filed information will be addressed in conformance with the Open Records Act. The statute requires that the quality improvement committee shall include network providers, and Doctors of Chiropractic will therefore be eligible for appointment to the committee by the governing body.

§10.81(b)(2): A commenter states that the scope of requirements for inclusion in the quality improvement work plan under §10.81(b)(2) is overbroad and excessive, creating mandates for networks based on information that is held by carriers rather than networks. For example, according to the commenter, the development of a work plan reflecting types of services and the population served in terms of age groups, disease or injury categories, and special risk status, such as type of injury is outside the purview of network operations.

Agency Response: The department does not have the authority to delete the requirement because it is statutorily mandated in Insurance Code §1305.303(f). The statute specifically requires networks to develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

§10.81(b)(2)(B)(iii): A commenter requests clarification on the requirement to include evaluation of clinical studies in the quality improvement work plan, including but not limited to whether the department is requiring the quality improvement program to include information regarding those network plan providers who are engaged in clinical studies, particularly if the network has delegated quality improvements tasks or is not engaged in any clinical studies itself. The commenter suggests that the rule should require evaluation of quality of clinical care and quality of services as set forth in Insurance Code §1305.303 instead of clinical studies.

Agency Response: The department does not believe either change is necessary. The requirement to evaluate clinical studies applies to the network or its delegated entities. If neither is performing clinical studies to evaluate the quality of medical care, then the method of evaluation of medical care by network providers may be substituted for this requirement.

§10.81(b)(2)(B)(iv): A commenter states that the language requiring a periodic update of treatment plans, return-to-work guidelines, and individual treatment protocols is too vague because the commenter believes that none of the guidelines in use are current.

Agency Response: The department does not agree with the commenter and declines to impose additional specific deadlines for such updating, but will monitor to determine whether additional rulemaking is needed. Insurance Code §1305.304 requires that each network adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols and further specifies that treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the carrier or network. Additionally, Insurance Code §§1305.351- 1305.355 set forth requirements concerning utilization review, retrospective review, reconsideration, and review by an independent organization, and Insurance Code §§1305.401 - 1305.405 set forth requirements regarding complaint initiation, procedures which are available to providers or injured workers who feel that treatment guidelines are outdated. Insurance Code §1305.303(g) requires that the annual quality improvement program report must be done annually, and §10.81(b)(2)(B)(iv) clarifies that the quality improvement work plan must include an evaluation of the adoption and periodic updating of guidelines.

§10.81(b)(2)(B)(vii): A commenter requests that §10.81(b)(2)(B)(vii) be changed to require the annual quality improvement work plan to include both provider billing and provider payment processes.

Agency Response: The department agrees and has changed the language of §10.81(b)(2)(B)(vii) to "provider billing and provider payment processes, if applicable".

§10.81(b)(2)(B)(xii): One commenter raises a concern that requiring the network to provide providers with information such as the insurer's or the employer's return-to-work processes and outcome data reflecting the number of time loss days paid from one year to another, for example, will present a problem for the network, which has no access to that information. According to the commenter, this concern is derived from the commenter's

questions about whether the requirement that the quality improvement work plan include an evaluation of return-to-work processes and outcomes means that the network must provide educational materials to providers on the importance of focusing on return-to-work efforts, and if so, whether the expected outcome is that a certain percentage of the providers received the training.

Agency Response: Insurance Code §1305.303 requires the network's quality improvement program to include a return-to-work program. The network quality improvement program must include monitoring of the return-to-work program and the success or failure of the program in returning injured workers to work. This process neither requires nor precludes provision of educational materials to providers. The outcome addressed in this rule is whether employees are returning to work and not whether materials were provided to a provider.

§10.81(c): A commenter states that the department's recognition of URAC Accreditation in §10.81(c) of the proposed rules will help to achieve the legislature's goal of providing high quality care to injured workers through workers' compensation health care networks and will further the legislature's intent that the workers' compensation health care network system resemble group health insurance plans as closely as possible.

Agency Response: The department thanks the commenter for support of the proposed rules.

§10.81(c)(1): A commenter states that §10.81(c)(1) creates a presumption of compliance for certain nonconditional accreditations, but according to the commenter, these accreditations are not specific to workers' compensation requirements and do not address the particular concerns of workers' compensation certified networks. The commenter therefore requests that this special presumption should be deleted.

Agency Response: The department does not agree that the presumption should be deleted. The intent of the legislation is to model workers' compensation health care networks on group health models. Network providers will be providing health care services to injured employees, and many national accreditation entities currently review group health care organizations' quality improvement programs to ensure that the programs meet health care standards. Since workers' compensation health care networks are providing health services, the same quality improvement standards are applicable to the networks.

§10.81(c)(1): A commenter states that language which creates a presumption of compliance for any national accreditation entity recognized by rules adopted by the commissioner of insurance should be deleted. The commenter states that this same standard should be applied in §10.102(a).

Agency Response: In response to the commenter's concerns, the department has changed proposed §10.81(c)(1) to delete the reference to "any other national accreditation entity recognized by rules adopted by the commissioner of insurance." The department does not understand the comment regarding §10.102(a), but §10.102(a) is based on the statutory requirements in Insurance Code §1305.351.

§10.81(c)(1): A commenter notes that Pain Program accreditation is not included among the accreditation entities recognized in §10.81(c)(1), and opines that this is one of the largest areas for abuse and overutilization of services.

Agency Response: The department does not believe that any change to the rule is required. The department recognizes that individual providers may be certified or accredited; however, this subsection addresses accreditation of the network itself.

§10.82: A commenter states that to avoid unnecessary administrative process, the Division should adopt a standard baseline credentialing mechanism. The commenter states that if networks wish to require additional evidence of suitability on the part of their selected providers, networks should be able to establish those criteria, but the commenter believes that the fundamental criteria set forth in a standard form and format would benefit all. Another commenter recommends that the department should specify one of the standard credentialing mechanisms for baseline credentialing, such as the Texas Standard Credentialing Application or Medicare Provider Certification. According to the commenter, if a network wishes to require additional specialty credentialing as part of its marketing program, the network should have that ability, but variations in credentialing which come about merely because networks have no guidance to utilize particular credentialing mechanisms will deter providers from participating in the system. Other commenters urge changing the rules to require the use of a standardized credentialing application.

Agency Response: The department declines to change the rule because the approach in the rule and the statute affords networks greater flexibility to review and select an appropriate credentialing mechanism. Section 10.82 establishes a standard baseline credentialing mechanism in accord with Insurance Code Chapter 1305. Section 1305.004(6) defines credentialing as a review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network. Section 1305.154(b) requires a network to perform functions related to credentialing in accordance with the requirements of Insurance Code Chapter 1305. The department will monitor the issue for possible future rulemaking.

§10.82: Commenters opine that site visits to treating providers as a required part of the credentialing process are overly burdensome and costly and ask that site visits to be optional or eliminated entirely. Another commenter requests that the rules be modified to allow networks to phase in site visits over a period of time. The commenter states that imposition of the requirement prior to the effective date of the initial contract with the provider as a requirement of network certification would be unduly burdensome to the network and providers. Another commenter recommends that the department allow established networks conditional certification until full compliance with the site visit requirement can be accomplished.

Agency Response: The department agrees with a phase-in of site visit requirements and has added §10.82(a)(1)(C)(vi) to the proposed rule to allow for a phase-in until not later than the first anniversary after the date of the network's certification. If the department or the network receives a complaint about a treating doctor who has not had a site visit, the network must perform a site visit within 30 days after notification by the department of the complaint, unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found.

§10.82: A commenter states that if physicians are given the right to review the credentialing files, comments or notes from the physician reviewer should be excluded.

Agency Response: The department disagrees and declines to change the rule. Without the right to review comments or notes

by the physician reviewer, a provider will be unable to respond to the content thereof or to correct erroneous information, which would be inconsistent with the requirement that a quality improvement program provide for a peer review action procedure as set forth in Insurance Code §1305.303(i).

§10.82: A commenter states that instead of auditing all entities to whom a network delegates, the network should be required to audit a specific percentage.

Agency Response: The department declines to make the requested change. The credentialing processes required in this section are based on national credentialing standards as required by the statute. The national credentialing standards to be reviewed require annual monitoring of all delegatees.

§10.82: Commenters state that the networks will be responsible for creating specific policies and procedures for their credentialing process but that there is no access to the specific credentialing policies by providers under the healthcare practitioner rights. Commenters request that this right be included in the rule to allow for a transparent credentialing process.

Agency Response: The department agrees that credentialing policies and procedures must be accessible to providers who are subject to the requirements and has added clarifying language in proposed §10.82(a)(1)(B) to provide that the credentialing criteria and procedures must be made available to network providers or applicants upon request.

§10.82(a)(1)(B): Commenters opine that the requirement that networks verify the status of financial disclosure filings for each provider in the network is overly burdensome and will result in greater costs to the system. The commenters request that the language be stricken and language requiring the individual provider to certify that he or she has complied with the financial disclosure requirements of the statute be substituted.

Agency Response: The department has modified the proposed §10.82(a)(1)(B) requirement regarding financial disclosures because of technical modifications that are necessary to make information regarding financial disclosures by providers who are on the ADL available online for networks.

§10.82(a)(1)(B)(iv): A commenter states that site visits by networks are not provided for within the text of the statute. The commenter asserts that the department cannot legally grant or share its authority with a public entity such as a network. However, if the authority to require such visits exists, according to the commenter, the department should state specifically what actions are and are not permissible during such a visit.

Agency Response: The department disagrees. Insurance Code §1305.303(a) requires a network to develop and maintain an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Insurance Code §1305.303(h) requires each network to implement a documented process for the selection and retention of contracted providers in accordance with rules adopted by the commissioner. The department believes that site visits are necessary to the network's quality improvement program and declines to make the requested change.

§10.82(a)(1)(B)(iv): Commenters requested changes to credentialing requirements related to time of contracting, length of credentialing process, addition of boards, limiting rights of doctors to see information, credentialing of hospital-based practitioners, monitoring of Medicare and Medicaid sanctions, selection criteria, primary source verifications, length of time to correct site visit deficiencies, and addition of the Executive Council of Physical Therapy and Occupational Therapy Examiners to the credentialing requirements.

Agency Response: The department declines to make the requested changes, as the standards are aligned with nationally recognized credentialing standards, as required by the statute. Under §1305.004(a)(6), "credentialing" means the "review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network."

§10.82(a)(1)(B)(viii): One commenter opines that the regulation is vague, unenforceable, and susceptible to an interpretation that could undermine the reforms that the statute attempts to achieve. The commenter states that there is no recognized medical specialty in "the treatment of costly conditions." According to the commenter, it is impossible to determine if a provider is a specialist in "the treatment of costly conditions" or an outlier health care provider who over-utilizes medical treatment that turns ordinary injuries into "costly conditions."

Agency Response: The department agrees and has modified proposed §10.82(a)(1)(B)(viii) to delete the reference to those who "specialize in the treatment of costly conditions."

§10.82(a)(1)(B)(viii)(I): A commenter asks the department to establish time frames and appeal procedures and define quality of care in this section because, as proposed, the rules allow for terminations and disciplinary actions based on unproved data and out-dated research or as retribution.

Agency Response: The department declines to change the rule. Under §1305.303, the network is responsible for assuring quality of care, and the network's governing body is ultimately responsible for the quality improvement program. Insurance Code §1305.152(c) requires that provider contracts include a clause regarding appeal by the provider of termination of provider status, in addition to provisions required by the commissioner by rule. To fulfill the network's quality assurance responsibilities, it follows that a network may suspend or terminate a doctor or health care practitioner if the network is concerned about the doctor or health care practitioner's quality of care.

§10.82(a)(1)(C)(ii), (D)(ii)(I): A commenter asks whether the rules in §10.82 indicate that if the network is accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) and JCAHO has approved the networks credentialing policies whereby Primary Source Verification (PSV) is delegated to a JCAHO accredited hospital, the department will accept the network's PSV processes to meet this requirement.

Agency Response: Yes, those JCAHO standards that are the same, substantially similar or more stringent than rule requirements meet this requirement.

§10.82(a)(1)(C)(iv): A commenter states that JCAHO allows a network to accept completed site survey questionnaires in lieu of an on-site visit and asks whether the department will accept these processes to meet the site visit requirement.

Agency Response: No. Under §10.81(c)(3) and §10.81(c)(4), JCAHO accreditation combined with site visits are acceptable. If a network is accredited by a national accreditation organization that has the same or similar standards as the standards required under the statute, the network is presumed to be in compliance with credentialing requirements. Because a site survey

questionnaire would not comply with the site visit requirement set forth in §10.82(a)(1)(C)(iv), the site visit requirement would have to be met separately.

§10.82(a)(1)(E): A commenter requests clarification regarding whether the term "institutional provider" is different from "health care facility" as defined in the Labor Code.

Agency Response: The department clarifies that the terms have the same meaning, and has changed §10.82(a)(1)(E) to delete the term "institutional providers" and to substitute the term "health care facility" to prevent confusion.

§10.82(a)(1)(E): A commenter requests clarification regarding whether the network is able to determine that Medicare certification is required for credentialing of health care facilities.

Agency Response: The network has the ability to determine which national accrediting bodies are appropriate for different types of health care facilities. An example of a national accrediting body is the Joint Commission on Accreditation of Health Care Organizations. However, Medicare certification is a required element of the credentialing process.

§10.82(a)(1)(E)(iii): A commenter states that this provision should be changed to state that the credentialing process for institutional providers must include evidence of compliance with other state or federal requirements rather than evidence of other applicable state or federal requirements. The commenter opines that the statute does not include language that gives the department the authority to regulate the networks' selection process for network providers. According to the commenter, this regulation conflicts with a network's ability to reject a provider's application if the network determines that the network has contracted with a sufficient number of providers. The commenter does not explain the basis for the belief that there is a conflict between the rule and the network's ability to reject an application.

Agency Response: The department agrees in part and has changed proposed §10.82(a)(1)(E)(iii) to add "compliance with" before "other applicable state of federal requirements." Insurance Code §1305.303 (h) requires the network to implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner. Insurance Code §1305.004 defines credentialing as a review of qualifications and other relevant information relating to a health care provider under nationally recognized standards. Therefore, the credentialing standards in this rule are based on nationally recognized standards, including NCQA, URAC, and JCAHO. The department does not agree that the rule conflicts with a network's ability to reject a provider's application with the network determines that the network has contracted with a sufficient number of providers because §10.42(a) expressly states that the network does not have to accept the application of a provider if it has determined it has sufficient providers of the same type already in the network.

§10.82(b): A commenter believes that the term "for cause" is vague and requests that the department define the term. The commenter believes that in the absence of a specific definition, lawsuits will put health care providers, networks and the department at the mercy of the courts.

Agency Response: The department declines to change the rule because it is the department interpretation that the statute is clear that quality issues are the responsibility of and within the discretion of the networks. Insurance Code §1305.303 requires the network to develop and maintain an ongoing quality improvement program, and the network's governing body is ultimately responsible for the quality improvement program.

§10.82(c): A commenter requests that the rule mandate that the required peer review process be performed by a doctor of the same specialty as the doctor being reviewed and cites an example of a pharmacist performing a medical necessity peer review on a physical medicine and rehabilitation specialist.

Agency Response: The department declines to make the requested change because the peer review process described in this subsection is not the same as the peer reviews performed to determine medical necessity in the utilization review process. The peer review process required under the Medical Practice Act examines quality of care and provider misconduct, rather than medical necessity.

§10.82(d): A commenter requests clarification that the rule requires the network to audit a percentage of a network's delegated entities and states that a requirement to audit all delegated entities would be overly expensive and burdensome.

Agency Response: The department disagrees and declines to make the requested change. Under the rule, networks are required to perform ongoing monitoring of all of the delegated entities with which they contract. The audits may be performed on a sample of files rather than reviewing all files, according to the network's monitoring plan.

§10.82(d)(2): A commenter questions whether the same rule for NCQA delegated entities applies if the network is accredited by JCAHO.

Agency Response: The same rule applies. The department has modified the proposed rule to specify that several national accreditation organizations other than the NCQA are acceptable.

§10.82(d)(4): One commenter opines that the language should be changed to permit the department to "inspect" the credentialing files of a delegated entity, while another commenter states that substituting the term "inspection" means that the department would have to visit the network instead of the network sending credentialing files to the department.

Agency Response: The department disagrees with both comments. Insurance Code §1305.251 grants the department the authority to examine the network's operations whether the review be on-site or at the department.

§§10.83, 10.83(a), and 10.2: A commenter opines that networks are not qualified to develop treatment guidelines and individual treatment protocols and that individual treatment protocols can be developed only by the evaluating therapist and doctor. According to the commenter, treatment guidelines have been used to deny treatment to or reduce reimbursement for severely injured patients, and that non-medical network employees are situated to decide what treatment is appropriate. Another commenter raises a concern that treatment guidelines are outdated and fail to consider the severity of an injury, the healing process of the individual patient, or the patient's job requirements. Another commenter requests that the language of §10.83(b) be changed to ensure that carriers and networks may not deny coverage for a compensable injury based upon a treatment guideline unless the guideline specifically addresses the injury and the treatment for the specific indication being requested. The commenter further requests that language be added to prohibit a carrier or network from denial of coverage based upon a treatment guideline that does not specifically address the injury and

the treatment for a specific indication in question. Other commenters state that specific treatment guidelines are unnecessary but should be consistent between networks if developed because it will otherwise be burdensome for providers to acquire and learn each different treatment guideline. Another commenter states that to achieve quality care and cost efficiency, all groups should work from the same scientific evidence base to ensure consistency within the workers' compensation system. According to the commenter, the studies by the National Institute of Medicine and the history of the use of adopted guidelines in California are instructive, demonstrate cost-saving potential, and support the use of evidence-based medicine as the basis for adopted treatment guidelines. Still another commenter opines that the presence of multiple guidelines within and between networks will create the potential for workers to receive differing levels of care; create uncertainty among stakeholders as to what is best for individual workers; and lead to increased delays and costs due to disputes. This commenter recommends that the department adopt the ACOEM Occupational Medical Practice Guidelines for use by workers' compensation networks.

Agency Response: The department does not have the authority to delete the requirement that each network adopt treatment guidelines and individual treatment protocols because the requirement is mandated in Insurance Code §1305.304. In addition, individual networks have discrete responsibilities to adopt treatment guidelines, and Insurance Code Chapter 1035 does not direct the department to prescribe particular treatment guidelines. Insurance Code §1305.304 specifies that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. Coverage for treatment will largely be determined by medical necessity. Labor Code §408.021(a) states that an employee who sustains a compensable injury is entitled to all "health care" reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates the definition of "health care" in Labor Code §401.011(19), which includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. As a further protection, §10.101(b) of these rules specifies that the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury. Furthermore, the rules contemplate that deviations may be requested by a specialist, and injured workers have access to specialists. Finally, the provider and injured employee have access to the independent review organization process and the complaints process if a dispute arises regarding deviations from treatment guidelines.

§10.83: A commenter opines that physical therapy services should be exempt from treatment guidelines, citing its belief that no published treatment guideline is considered evidence-based, scientifically valid, and outcome-focused for physical therapy for an injured worker. According to the commenter, guidelines adopted in other states have proven insufficient and have caused chaos in the system by: requiring injured workers to return to work with insufficient care to avoid re-injury; creating burdensome processes for providers, networks and payors to revise treatment plans to effectively manage a patient; causing physical therapy providers to opt not to participate in the workers' compensation system; and resulting in the use of treatment guidelines as limitations on care. The commenter also recommends requiring pre-authorization of all physical therapy care, with existing guidelines made available to providers and carriers as a guide rather than a limit on treatment.

Agency Response: The department does not have the authority to delete the requirement that each network adopt treatment guidelines and individual treatment protocols because the requirement is mandated in Insurance Code §1305.304. Providers and networks are well-positioned to address issues of treatment guidelines and individual protocols during the contracting process. While Labor Code §413.014 includes required preauthorizations for physical therapy services, that statute does not apply to workers' compensation networks pursuant to Insurance Code §1305.351(c). Further, while Insurance Code §1305.351(c) does not require networks to preauthorize services, if a carrier or network does use a preauthorization process, the requirements of Insurance Code §§1305.351 - 1305.355 and Chapter 10 of these rules apply. Networks and carriers shall decide which services, if any, will be subject to preauthorization, as set forth in §10.102 of these rules.

§10.83(a): One commenter suggests that, given the requirement that each network adopt evidence-based, scientifically valid, and outcome-focused guidelines, the department should add a new subsection requiring that a carrier or network provide health care in accordance with best practices consistent with "generally accepted standards of medical practice recognized in the medical community" to address situations in which no evidence exists or conflicting evidence exists with regard to treatment guidelines or if treatment guidelines or protocols do not address a specific injury or treatment requested or provided. The commenter states that this addition would be consistent with definitions of evidence-based medicine in the statute and in the Labor Code. Another commenter opines that the rule should require that authorized treatment that is not addressed in the treatment guidelines be in accordance with other evidence-based and scientifically valid medical treatment guidelines that are generally recognized by the national medical community because such language would allow for deviations from adopted treatment guidelines where necessary while ensuring that the deviation remains consistent with principles of evidence-based medicine. According to the commenter, the provider requesting a deviation from treatment guidelines should be required by the rules to provide a compelling reason for such deviation.

Agency Response: The department declines to make the requested changes because the department does not believe that they are necessary. Section 10.101(b) of these rules specifies that the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury. The department contemplates that deviations from treatment guidelines will be governed by medical necessity and that networks will develop processes to review requests for deviation, whether during utilization review or retrospective review. Providers and networks are well-positioned to address issues of treatment guidelines and individual protocols during the contracting process. The department will closely monitor the treatment of requests for deviation to determine whether future rulemaking is required.

§10.83(a): Commenters state that appropriate treatment guidelines include national specialty guidelines that are transparent,

peer reviewed, and evidence-based. One commenter opines that guidelines published by the National Guidelines Clearinghouse meets these requirements and requests that these quality indicators be included as part of the rule.

Agency Response: The department declines to make the requested change because §10.83(a) requires that networks adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary health care while safeguarding access to necessary care. In addition, networks, as they undertake the treatment guidelines adoption process, are not precluded from consideration of the quality indicators noted by the commenter.

§10.83(a): A commenter asks that the department impanel a group representative of all health care provider groups to write the guidelines so that they will be known to providers, accessible to any interested party, and enforceable. According to the commenter, current treatment and return-to-work guidelines are considered proprietary by networks and carriers and are only revealed to providers as a part of their termination from the network.

Agency Response: The department does not have the authority to make the requested changes because each individual network has the discrete responsibility to adopt treatment guidelines pursuant to Insurance Code §1305.304, and the statute does not direct the department to prescribe particular treatment guidelines. Insurance Code §1305.152(c)(2) requires provider contracts and subcontracts with a network to include a statement that the provider agrees to follow treatment guidelines adopted by the network, as applicable to an employee's injury. Section 10.83(c) of these rules requires networks to assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all providers.

§10.83(a): A commenter opines that treatment guidelines should be recognized and accepted by the specific health care provider group as valid guidelines for the care provided; e.g., occupational therapists would accept guidelines for occupational therapy care. The commenter recommends the development of a process for deviation from the treatment guidelines as indicated.

Agency Response: The department declines to make the requested changes because each individual network has the discrete responsibility to adopt treatment guidelines pursuant to Insurance Code §1305.304, and the networks will establish their own process for adoption of such guidelines. In addition, the networks are not precluded from utilizing specialty provider groups in this consideration and adoption process. Section 10.101(b) specifies that the carrier must establish a process for review of requests to deviate from treatment guidelines, whether as a part of utilization review or as a part of retrospective review. The process must include a requirement that the doctor or specialist request approval from the network for deviation from the treatment guidelines, return-to-work guidelines and individual treatment protocols where required by the particular circumstances of an employee's injury. Furthermore, these rules contemplate that deviations may be requested by a specialist, as injured workers have access to specialists. Finally, the provider or injured employee has access to the independent review organization process and the complaints process if a dispute arises regarding deviations from treatment guidelines. Consistent with the statutory requirements set forth in Insurance Code §1305.354(b) and §10.103(b)(2) additionally requires that reconsideration procedures include a review by a provider who has not previously reviewed the case who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review.

§10.83(b): A commenter supports the provision that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury and asserts that it should be strictly enforced.

Agency Response: The department appreciates the commenter's support. The department will closely monitor the utilization of treatment guidelines and will take enforcement action as necessary.

§10.83(c): A commenter requests that the rules require that a network's quality improvement program, guidelines and protocols be made available to providers before the provider contract is signed so that providers have a clear understanding of the policies and practices the network will require of them. Other commenters note that §10.83(c) could be interpreted to require a network to purchase costly copies of the treatment and return-to-work guidelines it uses for each of the providers contracted with the network and request a clarification stating that the network is responsible for informing the provider of the source of the treatment and return-to-work guidelines used by the network and that the provider is responsible for obtaining copies of those guidelines. Alternatively, commenters suggest that the rule require the network to "communicate" rather than "make available" the treatment and return-to-work guidelines.

Agency Response: Networks and providers are well-positioned to share requisites of the network's quality improvement program, guidelines and protocols during the contracting process. The department anticipates that individual providers will require access to the quality improvement program, guidelines, and protocols prior to signing a contract. The department has modified proposed §10.83(c) to clarify that a network must assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all network providers. The network may provide this information using any reasonable method that is accessible by the physician or provider, including e-mail, computer disks, paper or access to an electronic database.

§10.83(c): A commenter raises concern with the requirement in §10.83(c) that the network contractually require providers to follow treatment guidelines, return-to-work guidelines, and individual treatment protocols and requests that resultant disputes be addressed with peers of the same specialty as the provider who requests approval to deviate from guidelines rather than with an adjuster or case manager. The commenter requests clarification of who determines individual treatment protocols, and expressed fear that if a case manager has this responsibility, the case manager will be practicing medicine without a license.

Agency Response: The department does not have the authority to delete the requirement mandated in Insurance Code §1305.152(c)(2) that provider contracts and subcontracts include a statement that the provider agrees to follow treatment guidelines adopted by the network under §1305.304, as applicable to the employee's injury. Individual networks have discrete responsibilities to adopt treatment guidelines under Insurance Code §1305.304, and the department anticipates that the individuals or groups who undertake the adoption process at each network will vary between networks. The department declines to make the requested change on resultant disputes because it is the department's position that since a request to deviate from the treatment guidelines is required to be a part of the utilization

review or retrospective review programs, §10.103(b)(2), which requires that the reconsideration process include a review by a provider who is of the same or a similar specialty as a provider who typically manages the condition, procedure or treatment under review, is sufficient.

§10.84: A commenter asserts that treating doctors must also be allowed to serve as designated doctors or there will be no doctors to provide primary care for the injured workers.

Agency Response: Insurance Code §1305.101(b) states that a network doctor may not serve as a designated doctor or perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through a network with which a doctor contracts or is employed. Insurance Code Chapter 1305 does not prevent a network treating doctor from serving as a designated doctor for a patient in another network with whom the doctor is not contracted or employed.

§10.84: A commenter supports the provision in §10.84 that reflects the authority of networks to designate treating doctors and treating doctor specialties.

Agency Response: The department appreciates the commenter's support.

§10.84: A commenter states that the authority to define the term "treating doctor" is specifically given to the department by the legislature in the statute and that the department, rather than the insurance industry or networks, should specify by rule the definition of the term and show the criteria used to draft the definition.

Agency Response: The department declines to make this change because Labor Code §401.011(42) defines "treating doctor" and this definition is incorporated by reference in Insurance Code §1305.004(b)(10) and §10.2(b)(13). Insurance Code §1305.103(a) states that the network shall determine the specialty or specialties of doctors who may serve as treating doctors.

§10.85: A commenter expressed concern that the rules do not support a proposed referral system in the best interest of the patient or in support of cost-savings. The commenter states that surgical physicians are currently required to refer patients back to referring physicians once surgery is performed without consideration of the referring physician's ability to acquire or monitor therapy. According to the commenter, if a patient receives necessary care by a qualified licensed therapist, or a doctor with necessary training, appropriate care can be given initially, complications reduced, and the patient returned to work more quickly. The commenter suggests that the rule specify that if a patient requires emergency surgery, the doctor responsible for surgery should be the treating doctor and refer the patient for needed services. The commenter also suggests that the rule state that if a treating doctor refers a patient for surgery, the surgeon shall be the treating doctor and refer the patient for needed services related to the surgery. The commenter further suggests that when the surgery and related services are completed, the patient should then return to the original doctor.

Agency Response: The department does not have the authority to make the requested changes because Insurance Code §1305.103(a) requires that networks determine the specialty or specialties of doctors who may serve as treating doctors. Insurance Code §1305.103(e) requires that a treating doctor make referrals to specialists as needed. A referral to a surgeon should additionally allow the referral provider to provide reasonable related subsequent care as necessary.

§10.85: A commenter recommends that all employees be given a provider book for workers' compensation injuries similar to that of preferred provider organizations because the preferred provider organization system has worked well and is one with which most employees are familiar. According to the commenter, if employees obtain the list from the human resources department at the time of injury, the employees may be pressured or manipulated into going to doctors who have been promised economic benefit incentives for considering cost of the patients' care.

Agency Response: The department does not have the authority to make the requested change because it conflicts with the statutory provisions. Insurance Code §1305.005 requires that the employees be given a notice of network requirements and the employee information described in Insurance Code §1305.451, which includes a list of network providers updated at least quarterly. By statute, this notice must be given to current employees when the employer implements a network plan, to new employees within three days of hire, and to injured employees when the employer receives constructive notice of the injury. Under §10.60(g)(14), the employee must receive the complete list of network doctors at all required times for receiving the notice. If the department receives complaints from employees that they were manipulated into choosing from less than the entire list, the situation would be investigated and enforcement action taken as necessary.

§10.85: Commenters opine that §10.85 is confusing and request a change to the section to require: that an injured employee required to receive health care services with a network may select as the employee's treating doctor a doctor who the employee selected, prior to the injury, as the employee's primary care physician or provider under Chapter 843, as the terms "physician" and "provider" are defined in that chapter; that the doctor must agree to abide by the terms of the network's contract and to comply with the provisions of Subchapters B, D, and G of Chapter 1305 of the Insurance Code; that services provided by the doctor are considered to be network services and are subject to Subchapters H and I of Chapter 1305 of the Insurance Code; and that any change of doctor requested by an employee being treated by a doctor under this subchapter must be to a network doctor.

Agency Response: The department disagrees with the commenters' apparent belief that Insurance Code §1305.105 and §10.85 require that the HMO primary care physician be selected as the workers' compensation network treating physician prior to the injury. Such an interpretation would conflict with Insurance Code §1305.103(b), which states in part that an injured employee shall select a treating doctor for each injury. To prevent continued confusion, the department has modified proposed §10.85(d) to more closely track the language of Insurance Code §1305.105(a). The department has also added language to proposed §10.85(d) to recognize that not all provisions contained in Subchapters D through I of Chapter 1305 and commissioner rules adopted under those subchapters apply to treating doctors. The department declines to make any change that conflicts with Insurance Code §1305.104(a) and (b) because the department does not wish to impede the network's ability to allow for selection of a treating doctor from outside the network if the network so chooses. While Insurance Code §1305.104(a) and (b) make clear that initial selection of a treating doctor and selection of an alternate doctor must

be from within the network, selection of a subsequent treating doctor must be authorized only according to procedures and criteria established by the network as set forth in Insurance Code §1305.104(c).

§10.85(a): A commenter requests a revision of §10.85(a) to reflect that the selection of the treating doctor must be from the list provided by the network of all contracted treating doctors designated by the network.

Agency Response: The department declines to make this change because to do so would deprive an injured employee who is covered under an HMO plan of the right to select the employee's HMO primary care physician or provider as the treating doctor in accordance with Insurance Code §1305.105. The language in §10.85(a) mirrors Insurance Code §1305.104(a) which entitles the employee to his or her initial choice of a treating doctor from the networks' list of treating doctors.

§10.85(d): Commenters note the importance of insurer and network knowledge of the identity of the injured employee's treating doctor for purposes of claim investigation, determination of what the compensable injury is, initiation of contacts with the treating doctor, initiation of case management, coordination of healthcare requests by referred healthcare providers with the treating doctor, and follow-up on quality of health care issues. The commenters therefore request that the department add a new subsection to require that an injured employee notify the insurance carrier and network of the employee's choice of treating doctor and any subsequent change of treating doctor in accordance with §1305.104(b) - (e) of the Texas Insurance Code. The commenters also request language stating that the network shall notify the insurance carrier of any decision made by the network's medical director to allow the injured employee to use a specialist as the employee's treating doctor in accordance with §1305.104(f) - (i) of the Texas Insurance Code.

Agency Response: The department declines to make these requested changes because such provisions could affect or delay the employee's right to timely receipt of services. Pursuant to Insurance Code §1305.104(b), an employee who is dissatisfied with the initial choice of treating doctor is entitled to select an alternate treating doctor from the network's list of treating doctors who provide services within the service area in which the injured employee lives by notifying the network in the manner prescribed by the network. The carrier and network are well-positioned to negotiate additional notifications between the carrier and network during the contract process, but such provisions should not affect or delay the employee's right to timely receipt of services.

§10.85(d): A commenter raises concern that the language in this subsection does not actively reflect the statute in that the proposed rules appear to state that the employee must select the workers compensation provider prior to the employee's injury, whereas the commenter believes the statute only requires that the person have selected their HMO primary care provider prior to their injury.

Agency Response: The department agrees with the commenter's concern and has modified proposed §10.85(d) to more closely track the language of Insurance Code §1305.105.

§10.85(b): A commenter recommends that the title of §10.85(b) be revised to clarify that the provision addresses a change of treating doctor within the network.

Agency Response: The department does not agree with this change because it could impede the network's ability to allow for selection of a treating doctor from outside the network if the network so chooses. Insurance Code §1305.104(b) makes clear that an alternate doctor must be a network doctor. However, selection of a subsequent treating doctor must be authorized only according to procedures and criteria established by the network as set forth in Insurance Code §1305.104(c).

§10.85(c): A commenter recommends that it will better reflect statutory intent to change §10.85(c) to provide that the injured employee may apply to the network's medical director to use a specialist that is in the same network as the injured employee's treating doctor for either all health care or for all health care related to the treatment of chronic pain. Another commenter raises concern that §10.85(c) may suggest that specialists cannot be considered treating physicians from inception of the injury and expresses fear that employees will always need to undertake a complicated process to obtain a specialist as their treating doctor.

Agency Response: The department does not have the authority to change the requirement in Insurance Code §1305.104(h) that a physician specialist, if serving as a treating doctor, must agree to accept the responsibility to coordinate all of the injured employee's health care needs. Insurance Code §1305.104 provides that any doctor listed as a treating doctor in the list provided quarterly by the network, regardless of specialty, may be initially selected by the employee as an initial or alternate treating doctor.

§10.85(d): Commenters support this provision in that it tracks statutory language and requires selection of the treating physician prior to the injury. Commenters request an addition to §10.85(d) to require an employee to provide both proof that selection of the primary care physician used by the employee in the employee's HMO as the employee's treating doctor occurred prior to the date of injury and proof that the primary care physician has agreed to abide by the terms of the network's contract and comply with the applicable provisions of the statute. According to the commenter, the employee is best-positioned to provide this information. Similarly, some commenters urge that the rules be changed to require that an employee is responsible for contacting the HMO primary care physician regarding selection as a treating doctor and obtaining the doctor's agreement, on a form designated by the network, prior to the injury, because care will otherwise be delayed. Another commenter notes that employers hold employees' private medical plan information and are thus positioned to confirm an employee's status as a participant in an HMO. The commenter therefore requests that a form be developed for submission by the employee to the employer containing the employee's selection of the HMO primary care physician as the treating doctor in the workers' compensation network prior to the injury, which form would include the employee's signature, the name of the medical provider, and a signed statement from the provider agreeing to abide by applicable statutes and regulations.

Agency Response: The department disagrees with the commenters' apparent belief that Insurance Code §1305.105 and §10.85 require that the HMO primary care physician be selected as the workers' compensation network treating doctor prior to the injury. Such an interpretation would conflict with Insurance Code §1305.103(b), which states in part that an injured employee shall select a treating doctor for each injury. To prevent continued confusion, the department has modified proposed §10.85(d) to more

closely track the language of Insurance Code §1305.105(a). The department disagrees that the injured employee is best-positioned to act as middleman between the carrier and physician, as the employee has no knowledge of a network's contract terms or the applicable provisions of the statute. A carrier has several options for obtaining proof that the employee selected the HMO physician prior to the date of injury, including, but not limited to, obtaining a copy of HMO ID cards. The department declines to dictate which option a carrier should choose. The department does not believe that a form needs to be developed or that the request should be required to be submitted through the employer. The department declines to develop or require use of such a form, as it could create further delays to care of the injured employee.

§10.85(d): A commenter requests a technical change to §10.85(d) wherein the final sentence would read: "The network shall grant an employee's request..." rather than "a" employee's request..."

Agency Response: The department agrees and has made a change to grammar and punctuation in this subsection.

§10.85(d): Commenters request that the rules specify that a primary care physician is not available for choice as an alternate treating doctor because the statute is clear that any change of treating doctor must be within the network.

Agency Response: The department agrees with the commenter that the statute is clear and therefore the requested change is not necessary.

§10.86: A commenter states that this entire section should change to require each network to establish and maintain claims receipt logs that accurately record the date the network received the claim; the date the claim was approved for payment; the date the check was issued for payment; and the date check was mailed for payment.

Agency Response: The department declines to make the requested change because this section implements Insurance Code §1305.107, which addresses telephone access for discussion of employee care and for responses to requests for information, including information regarding adverse determinations. The commenter's request is directed to provider payment concerns which are addressed in Labor Code §408.027.

§10.86: A commenter requests clarification of the intent of §10.86, stating that if the section's purpose is to ensure adequate network access and availability, this can be accomplished by requiring networks to maintain around the clock access through the toll-free number already required under §10.60(g)(2). Alternatively, the commenter states that if the section's purpose is to address complaints and grievances, the commenter feels the need is already addressed in §10.120 and §10.121. According to the commenters, a requirement that networks maintain a system log would be overly burdensome and difficult to manage. Some commenters opine that the provisions of §10.86 exceed statutory language, constitute micromanagement of the networks' day-to-day operations, and are thus contrary to the intent of the Texas Legislature and author of the statute. The commenters request that the department either delete §10.86 or substitute the language of Insurance Code §1305.107 for the language as proposed.

Agency Response: The department declines to make the requested changes because the information required to be provided under §10.86 is the minimum information a network must be able to demonstrate that it provides in order to show itself compliant with Insurance Code §1305.107, which provides a mechanism for discussion of employee care and response to requests for information, including information regarding adverse determinations.

§10.86: A commenter believes that all information regarding the set up and maintenance of telephone access, call documentation, and access logs should be available under the Texas Open Meetings Open Records Act in order to protect all parties from unsubstantiated accusations.

Agency Response: Networks are not generally required to file telephone access logs with the department. With regard to such information if filed with the department, the department will comply with all requirements of the Public Information Act.

§§10.100, 10.101 and 10.102: A commenter asserts that utilization reviews should only be conducted by health care providers licensed in the state of Texas. In recognition of the role of paper review in utilization review, cost control and quality of care determinations, and in the absence of printed published standards, the commenter requests that paper review opinions be held to standards as set forth in the TCA Quality Standards for Opinions Based Upon Paper Review by department rule.

Agency Response: There is no statutory or regulatory requirement that utilization review be conducted by health care providers licensed in Texas. The department does not have the authority to make the requested change because of the provision in Insurance Code §1305.304 that provides that each network will adopt treatment guidelines, return-to-work guidelines and individual treatment protocols and the provision in §1305.351(b) that provides that any screening criteria used for utilization review or retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines. Consistent with §1305.304, §10.83(a) provides that each network will adopt treatment guidelines, return-to-work guidelines and individual treatment protocols. Section 10.101(a) requires that "screening criteria used for utilization review and retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines, return-to-work guidelines, and individual treatment protocols. Section 10.101(b) requires that the carrier's utilization review program and retrospective review program must include a process for a treating doctor to request approval from the network for a deviation from adopted guidelines and protocols where required by the particular circumstances of the injury. The department anticipates that approvals for such deviations will be governed by medical necessity. No further change to the language is required.

§§10.100 - 10.104: A commenter states that the utilization review guidelines should interface with case management and cost containment in terms of the return-to-work guidelines.

Agency Response: Insurance Code §1305.303(j) requires networks to have case management programs with certified case managers and requires case managers to work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work. Section 10.81(a) requires networks' quality improvement programs to include return-to-work and medical case management programs.

§10.101: A commenter states that treatment guidelines should not be used to arbitrarily deny treatment, but networks should insist on a compelling reason to deviate from the guidelines before nonconforming requests are approved. According to the com-

menter, traditional definitions of appropriateness for many tests and treatments are generated from the prior interpretations of workers' compensation statutes rather than based in evidence; therefore, the commenter suggests a change to the language to require that treatment not addressed in the treatment guidelines be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and that are scientifically valid.

Agency Response: Section 10.101(b) specifies that "the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury." The department contemplates that deviations from treatment guidelines will be governed by medical necessity. Also, the provider and injured employee have access to the independent review organization process and the complaints process set forth in Subchapters F and G of the rules if a dispute arises regarding deviations from treatment guidelines. The rule is consistent with the statute in §1305.304. Section 1305.304 provides that treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed in a carrier's or network's adopted treatment guidelines. Section 10.42(b)(2) indicates that a provider has an obligation to follow a network's adopted treatment guidelines, return-to-work guidelines, and individual treatment protocols as applicable.

§10.101: A commenter requests details about the process for requesting a deviation from treatment guidelines, screening criteria and individual treatment protocols because such a process will be time-consuming for the physician's staff. The commenter further requests that a resolution of the request should occur within 72 hours from the date of request.

Agency Response: The department disagrees that the department should provide the process details as requested by the commenter because to assure flexibility and maximum quality improvement, networks should develop this process, including timelines for a response to the request. Therefore, §10.101 requires the network to develop a process for requests from providers to deviate from the treatment guidelines, return-to-work guidelines and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.101: A commenter opines that it is important for these rules to be consistent with Insurance Code Article 21.58A §4(i), and states that screening criteria must be used to determine only whether to approve the requested treatment. The commenter also opines that denials must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Agency Response: The rules do not deviate from the statutory requirements relating to the use of screening criteria or the involvement of an appropriate provider upon issuance of an adverse determination. Insurance Code §1305.351 and §10.100 provide that the requirements of Insurance Code Article 21.58A apply to utilization review conducted in relation to workers' compensation health care network. However, in the event of a conflict between Insurance Code Article 21.58A and Chapter 1305, Insurance Code Chapter 1305 controls. Accordingly, utilization review performed in relation to the network will be consistent with Article 21.58A unless a conflict with Chapter 1305 exists.

§10.101(b): Commenters disagree with the proposed language in §10.101(b) that requires that a carrier's utilization review program include a process requiring a treating doctor or specialist to request approval from the network to deviate from treatment guidelines, screening criteria, and individual treatment protocols. The commenters do not agree that the statute requires such approval but instead contemplates that high-performing providers should be allowed to so deviate, at the carrier's or network's discretion. Other commenters recommend deletion of this subsection because Insurance Code Chapter 1305 authorizes networks to determine which services are subject to preauthorization within the scope of the contract between the provider and the network. According to the commenters, the proposed subsection would mandate that services be preauthorized in situations that are not contemplated in the law. Another commenter states that treating doctors and specialists will need to document the medical necessity of providing health care that deviates from the treatment guidelines, screening criteria, and individual treatment protocols and that health care should be reviewed on a retrospective basis to determine if the deviation was appropriate and if the health care was reasonable, medically necessary, and related to the compensable injury.

Agency Response: The department recognizes that in a system in which providers must follow a network's selected treatment guidelines, return-to-work guidelines and individual treatment protocols, it is necessary to provide a mechanism by which the provider may request a deviation from such guidelines where the individual circumstances of a case so justify. The adopted rules allow networks to set up their own processes for responding to requests for deviation; proposed §10.101(b) has been modified to require that the carrier's utilization review program and retrospective review program include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.102: A commenter states that he already struggles because the carriers have three days to deal with pre-authorization and take every bit of three days. The commenter requests that the rules require that pre-authorization requests be addressed by the network within 24 hours.

Agency Response: The department does not have the authority to make the requested change because the three-calendar-day requirement is mandated under Insurance Code §1305.353(c) and (d). Section 10.102(a) provides that if a carrier or network uses a preauthorization process within a network, the requirements of Insurance Code §§1305.351 - 1305.355 and this chapter apply.

§10.102: A commenter supports preauthorization without retrospective review and would like to return to preauthorization that has some defined parameters that give providers a guideline as to what they can expect.

Agency Response: Insurance Code §1305.351(c) provides that if a network or carrier uses a preauthorization process within a network, the utilization review and retrospective review requirements of Subchapter H of Chapter 1305 and the commissioner rules apply. Networks and carriers are free to structure their preauthorization procedures as they choose consistent with Subchapter H of Chapter 1305 and the commissioner rules.

§10.102(a): A commenter states that this subsection is contradictory to the statute because preauthorization does not apply

to network providers. The commenter states that if network has preauthorization requirements, then the Insurance Code applies. If so, the commenter believes that retrospective review should not apply.

Agency Response: The department disagrees that this subsection is contradictory to the statute. The commenter, however, is correct that Insurance Code §1305.351 does not require preauthorization, but if a carrier or network uses a preauthorization process within a network, the provisions of Insurance Code §§1305.351 - 1305.355 and this chapter control. The commenter is also correct that a service that has been preauthorized will not be subject to retrospective review. Insurance Code §1305.153(b) prohibits a carrier or network which has preauthorized a health care service from denying payment to a provider except for reasons other than medical necessity, and Insurance Code §1305.004(a)(21) defines "retrospective review" as the process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

§10.102(a): Commenters agree with §10.102(a) of the proposed rules, but state that because the statute and the rules create separate preauthorization requirements for networks, it is important that carriers, networks, and providers have a clear understanding of the meaning and effect of preauthorization.

Agency Response: The department disagrees that the statute and rules create separate preauthorization requirements. While the adopted rule does not contain all of the statutory provisions, the statute and rules together contain compatible preauthorization requirements. The statute and rule must be read together. The department believes that the statutory definition of "preauthorization" is clear and understandable for all parties. Insurance Code §1305.153(b) provides that services that have been preauthorized may not be later denied due to lack of medical necessity. The department believes this is a clear directive to networks and is also understandable for providers and other parties.

§§10.102(b), 10.102(c)(3) and 10.103(a)(4)(B)(v): The commenter requests that more specific information be included in the notice of adverse determination so that providers fully understand the reason for a denial of a treatment or service.

Agency Response: The department declines to make the requested change because the department believes that the provisions contained in the statute and in §10.102(c) include adequate information, such as the principal reasons and clinical basis for the determination, to enable a provider to understand the basis of the decision.

§10.102(b): The commenter believes that a designated representative of the employee, including office staff or a referral health care provider, should be able to request preauthorization or appeal a denial as allowed under the existing TWCC rules that address this issue. In addition, the commenter requests a change in language to require a person performing utilization review to notify such a designated representative of a determination.

Agency Response: The requested change is not necessary. Section 10.102(b) requires that the person performing utilization review notify the employee's representative and the requesting provider of the determination. If an employee has designated a representative, there is nothing in the statute or the rules preventing the representative or the treating provider from participating in the applicable portions of the utilization review process, including appeals and preauthorizations.

§10.102(c)(4): Some commenters opine that Labor Code §408.023(h) should govern §10.102(c)(4) rather than Labor Code §408.0231(g), which is specific to peer reviews. One commenter therefore request a language change to reflect that a notice of adverse determination must include, for any provider consulted, validation that the provider is licensed in Texas or under the direction of a doctor licensed to practice in this state in accordance with Labor Code §408.023(h). Another commenter requests deletion of the provision.

Agency Response: The department agrees that Labor Code §408.0231(g) is specific to peer reviews and, in §10.102(c)(4), has deleted "and a validation that the provider is licensed in Texas in accordance with Labor Code §408.0231(g)". The department does not have the authority to require Texas licensure for providers involved in the utilization review decision. Utilization review by networks or their designees is governed by Insurance Code Chapter 1305 and Article 21.58A. These statutes do not require Texas licensure for providers involved in the utilization review decision.

§10.102(d) and (g): A commenter recommends additional language requiring that, on receipt of a preauthorization request from a provider for proposed services, equipment or supplies, the insurance carrier or network shall issue and transmit a determination indicating whether the proposed health care services are preauthorized within 48 hours.

Agency Response: The department does not have the authority to make the requested change because the deadlines for a response to a request for preauthorization are mandated by the applicable statutes in Subchapter H, relating to utilization review and retrospective review.

§10.102(d): Commenters request that this provision be expanded to allow a provider to seek preauthorization of any proposed service and not just those services that must be pre-authorized. Another commenter requests that the department add a new subsection to §10.102 stating that a carrier may not deny payment to a provider except for reasons other than medical necessity if a carrier or network preauthorizes a service or item under this subchapter.

Agency Response: The department does not have the authority to allow a provider to seek preauthorization of any proposed service because Insurance Code §1305.351 does not require a network to use preauthorization of services. It is not necessary to make the requested change relating to preauthorized services and the prohibition against denials based on medical necessity because it is in the statute and is applicable to networks whether included in the rule or not. The statute and the rule must be read together.

§10.102(d), (f) and (g): The commenter requests language stating that no retrospective denial will be allowed, noting that networks are seeking up to 35% discounts from current workers' compensation fee guidelines and that providers may not be able to afford to continue providing service to workers' compensation patients. According to the commenter, retrospective denials have resulted in marked financial loss for providers and the new rules make it more difficult for providers to contest denials, making it essential that the insurance company be required to respond to providers' request for preauthorization with no right to deny retrospectively.

Agency Response: The department does not have the authority to repeal a statutory provision by rule. Subchapter H of Insurance Code Chapter 1305 specifically requires a network to have

both utilization review and retrospective review, thereby recognizing a network's ability to engage in retrospective review. Insurance Code §1305.351 does not require that a network make use of its ability to require preauthorization of services. The network has discretion to decide which, if any, services will require preauthorization.

§10.102(f): A commenter asks if the next business day will suffice for provision of the notice of determinations in cases involving post-stabilization

Agency Response: No. Insurance Code §1305.353(f) and the rule require that notice be transmitted "within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request." This provision is statutorily mandated and cannot be changed to allow a delay until the next business day.

§10.102(f): A commenter requests clarification of the meaning of post-stabilization treatment and treatment involving a life-threatening condition as opposed to emergency services which do not require preauthorization. The commenter also requests clarification that preauthorization is not required should treatment become necessary outside of normal business hours and states that such treatment would remain subject to retrospective review. Another commenter suggests the removal of subsection (f) from §10.102 and the deletion of the definition of "life-threatening condition" from the utilization review section of these regulations as the commenter opines that this is a change from what is presently required for workers' compensation utilization review agents in the state of Texas. The commenter also suggests that life-threatening conditions and post-stabilization care be reviewed retrospectively.

Agency Response: Post-stabilization treatment relates to treatment delivered immediately following emergency services where the patient has been stabilized. Emergency services are services that require immediate treatment and cannot be delayed for preauthorization, while life-threatening conditions will allow a short delay for preauthorization of proposed services. The department does not have the authority to remove subsection (f) of §10.102 because the provision is statutorily mandated in Insurance Code §1305.353. This standard is applicable to care delivered through a workers' compensation health care network without reference to any previously applicable standards that were changed by the passage of the statute.

§10.102(g): A commenter opines that the statutory deadlines set forth in Labor Code §408.027 and Insurance Code §1305.106, which give the carrier or network 45 days to audit the bill and make a determination as to whether or not utilization review is necessary, are in conflict with the provision that if the network provider requests retrospective review of medical treatment, the utilization review agent must transmit the retrospective review determination to the provider within three calendar days of the request. The commenter states that submission of a medical bill for payment of medical services not requiring preauthorization is effectively a request for retrospective review of treatment and a request for payment.

Agency Response: The department agrees and has removed the reference to "retrospective review" in proposed §10.102(g) and has added a new subsection (h) that makes the retrospective review determination deadlines consistent with the payment deadlines in Labor Code §408.027. The commenter is correct that the submission of a claim is effectively a request for retrospective review and no further request is necessary.

§10.102(g): Some commenters recommend that the person performing utilization review issue and transmit the determination no later than three "working" days rather "calendar" days; one states that the change would provide flexibility during three-day holiday weekends; and another expresses concern that providers will submit all of their bills on Fridays to preclude utilization review. Another commenter alternately requests changing the three calendar day requirement to five calendar days. Another commenter recommends allowance of only one business day for approval or denial of preauthorization requests, believing that there is sufficient profit to offset the costs of this need and that persons performing the review will fully use any time allotted.

Agency Response: The department does not have the authority to make the requested change because Insurance Code §1305.353(d) requires that preauthorization requests other than those addressed in Insurance Code §1305.353 (e) and (f) must be issued and transmitted not later than the third calendar day after the date the request is received.

§10.103(a): A commenter feels that the requirement to make available and maintain a written description of reconsideration procedures increases the exposure for the costly administrative burden to the system and recommends deleting it.

Agency Response: The department does not have the authority to delete the statutorily mandated requirements of Insurance Code §1305.354(a) in this section.

§10.103(a)(3): A commenter requests deletion of the requirement of sending an acknowledgment letter to the provider within five days of receipt of a request for reconsideration, stating that the requirement is administratively burdensome and unnecessary. Another commenter notes that there is not a similar requirement for the workers' compensation system. Another commenter states that five days is too long and requests that the acknowledgement letter instead be sent to the requesting party in two days. Another commenter opines that five days is insufficient time and requests ten days in which to provide this acknowledgment.

Agency Response: The department does not have the authority to make the requested change because the requirement is statutorily mandated in Insurance Code §1305.354(a)(3). This statutory standard is applicable to care delivered through a workers' compensation health care network without reference to any other standard for the workers' compensation system.

§10.103(a)(5): A commenter states that allowing thirty days for the person performing utilization review to notify the requesting party of the determination is too much time, instead, the commenter requests notification by the seventh business day.

Agency Response: The department does not have the authority to change the statutorily mandated requirement in Insurance Code §1305.354(a)(5).

§10.103(b)(3): Commenters request that this provision be changed to provide for no more than three working days for completion of reconsideration, with some commenters recommending an exception for a life-threatening condition, in which case the completion should not exceed one calendar day. Other commenters suggest changing the provision such that it would apply only to post-stabilization care denials, denials involving life-threatening conditions, and denials of continued hospitalization.

Agency Response: The department does not have the authority to change the statutorily mandated requirement in Insurance Code §1305.354(b).

§10.104 and §10.104(a)(2)(B) and (e): Commenters request additional language requiring that a network provide and an independent review organization consider the network's treatment guidelines as part of the independent review process outlined in §1305.355 of the statute in light of the emphasis in the proposed rules on treatment guidelines as set forth in §10.22(19) and §10.104(a). One commenter suggests that treatment guidelines will have little value if such language is not added, and another notes that such consideration is needed for proper evaluation for quality improvement purposes. Another commenter notes that the independent review organization should recognize that a network's treatment guidelines are just "guidelines" and are not a basis under the statute for a carrier to deny payment.

Agency Response: The department declines to make this change without providing all interested parties an opportunity to comment. The change would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The independent review organization is not precluded from considering the treatment guidelines; however, the statute does not require the independent review organization to use the guidelines in making its determination. The carrier may not deny treatment for a compensable injury solely on the basis that the treatment under consideration is not within the treatment guidelines under §10.83(b).

§10.104: The commenter opines that 120 days should be the minimum deadline to request review by an independent review organization because of the risk that the administrative burden on the provider might drive reputable providers from the system.

Agency Response: The department does not have the authority to make the requested change because the deadlines in the rule are statutorily mandated in Insurance Code §1305.355.

§10.104(a): A commenter requests that the definition of "health care reasonably required" be incorporated into §10.104(a) making the provision applicable to a person who denies that the treatment is not in accordance with generally accepted standards of medical practice recognized in the medical community.

Agency Response: The department does not agree with the requested change because it would add the "health care reasonably required" standard to the utilization review and independent review processes. However, the "medically necessary and appropriate" standard is referenced by the statute, which indicates that Insurance Code Article 21.58A applies to utilization review in the event that there is no conflict between Article 21.58A and Chapter 1305.

§10.104(a)(2)(B): A commenter requests deletion of the requirement to provide treatment guidelines to an independent review organization, stating the requirement is excessive and may create concerns with copyright issues.

Agency Response: The department does not have the authority to make the requested change because Insurance Code §1305.355(a)(2)(B) requires the utilization review agent to provide to the independent review organization any documents used by the utilization review agent in making an adverse determination. The department declines to make the suggested change.

§10.104(g): A commenter states that the term "decision" should be replaced with the term "determination" in order to be consistent with the statutory language found in Insurance Code §1305.355(f) and (g).

Agency Response: The department believes that the term "decision," as used in this subsection, is clear and does not require change. Additionally, because the independent review organization's finding may favor the provider or injured employee, use of a different term precludes confusion with the term "adverse determination."

§10.104(g): A commenter questions whether a carrier must pay for health care during the pendency of an appeal for judicial review where an employee appeals an independent review organization's decision in support of denial of care, stating that such a requirement would defeat the purpose of the denial.

Agency Response: Insurance Code §1305.355(f) states that a determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of the appeal. The carrier is therefore liable for the care during that time period.

§10.120: A commenter requests that the rule more specifically set forth the procedures used in processing complaints in order to ensure consistency within the system.

Agency Response: Insurance Code §1305.401(a) requires networks to implement and maintain a complaint system that provides reasonable procedures to resolve oral or written complaints. This provision in the statute allows networks the flexibility to set up their own processes for complaint-handling. The department will monitor network complaint procedures for reasonableness and to determine if any future rulemaking is necessary.

§10.121(c): A commenter asks whether the complaint timeframes outlined in §10.121 are considered calendar days or business days.

Agency Response: Unless indicated otherwise, all references to days in the rules are calendar days. The department, however, has added the term "calendar" in proposed §10.121(c) to avoid confusion since the term "calendar" is already included in §10.121(a).

§10.121(c): A commenter asserts that 10 days is a more appropriate time frame for a network to investigate a complaint than the 30 days that §10.121(c) requires because data establishes that wasted time increases medical costs.

Agency Response: Insurance Code §1305.402(b) requires networks to investigate, as well as resolve a complaint within 30 calendar days. To maintain consistency with the statute, §10.121(c) requires networks to issue resolution letters within 30 days.

§10.121(e): Commenters request that §10.121(e) include language that requires that complaint logs be considered public knowledge available to parties under the Open Records Act. Another commenter requests that the logs should be made available within 30 days of written request.

Agency Response: The department declines to make the suggested change because the statute does not require periodic filing of the complaint log with the department. The Public Information Act is applicable to governmental bodies and not private en-

tities. The department reviews the complaint logs during examinations. Insurance Code §1305.502 requires the annual publication of consumer report cards that include "consumer satisfaction with care" data, which may include some of the complaint log data.

For with changes: Association of Fire & Casualty Insurers of Texas; American College of Occupational and Environmental Medicine; American Insurance Association; Baylor Health Care System; Beech Street Corporation; Berkstresser & Associates Rehabilitation Advisors; Case Management Solutions; Center for Orthopaedic Specialties; Concentra; Inc.; Doctors Guild of Texas; FairIsaac Corporation; First Health Group Corp.; ENCORE; Insurance Council of Texas; Liberty Mutual Group; Lubbock Diagnostic Radiology, L.L.P.; Medtronic; Office of Public Insurance Counsel; Pinnacle Anesthesia Consultants, P.A.; Property Casualty Insurers Association of America; Texas AFL-CIO; Texans for Workers' Compensation Reform and Texas Self Insurance Association; Texas Ambulatory Surgery Society; Texas Association of Business; Texas Chiropractic Association; Texas Hospital Association; Texas Medical Association; Texas Mutual Insurance Company; Texas Occupational Therapy Association, Inc.; Texas Pharmacy Association; Physical Therapy Association; The Boeing Company; Zenith Insurance Company; State Office of Risk Management; USA Managed Care Organization; The American Accreditation Healthcare Commission/URAC; Workers Compensation Pharmacy Alliance; Work & Rehab; Injury Management Organization; and Texas Property and Casualty Insurance Guaranty Association.

Against: None.

SUBCHAPTER A. GENERAL PROVISIONS AND DEFINITIONS

28 TAC §10.1, §10.2

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.1. Purpose and Scope.

(a) This chapter implements provisions of the Workers' Compensation Health Care Network Act, Insurance Code Chapter 1305, and provides standards for the certification, administration, evaluation, and enforcement of the delivery of health care services to injured employees by networks contracting with or established by:

(1) workers' compensation insurance carriers;

(2) employers certified to self-insure under Labor Code Chapter 407;

(3) groups of employers certified to self-insure under Labor Code Chapter 407A; and

(4) governmental entities that self-insure, either individually or collectively, under Labor Code Chapters 501 - 505, except as described in subsection (c) of this section.

(b) This chapter applies to:

(1) each person who performs a function or service of a workers' compensation health care network as defined by §10.2 of this subchapter (relating to Definitions), including a person who performs a function or service delegated by or through a workers' compensation health care network; and

(2) an insurance carrier as defined by Labor Code §401.011 that establishes or contracts with a workers' compensation health care network.

(c) This chapter does not apply to health care services provided to injured employees of a self-insured political subdivision or injured employees of the members of a pool established under Government Code Chapter 791 if the political subdivision or pool elects to provide health care services to its injured employees in the manner authorized under Labor Code §504.053(b)(2), relating to self-insured subdivisions or pools directly contracting with health care providers, or by contracting through a health benefits pool established under Local Government Code Chapter 172.

(d) This chapter does not authorize a workers' compensation insurance policyholder who purchases a deductible plan under Insurance Code Article 5.55C to contract directly with a workers' compensation health care network for the provision of health care services to injured employees.

(e) If a court of competent jurisdiction holds that any provision of this chapter is inconsistent with any statutes of this state, is unconstitutional, or is invalid for any reason, the remaining provisions of this chapter shall remain in full effect.

(f) This chapter becomes applicable January 1, 2006.

§10.2. Definitions.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are not medically necessary or appropriate.

(2) Affiliate--A person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(3) Capitation--A method of compensation for arranging for or providing health care services to employees for a specified period that is based on a predetermined payment for each employee for the specified period, without regard to the quantity of services provided for the compensable injury.

(4) Complainant--A person who files a complaint under this chapter. The term includes:

(A) an employee;

(B) an employer;

(C) a health care provider; and

(D) another person designated to act on behalf of an employee.

(5) Complaint--Any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or

(B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) Credentialing--The review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) Emergency--Either a medical or mental health emergency.

(8) Employee--Has the meaning assigned by Labor Code §401.012.

(9) Fee dispute--A dispute over the amount of payment due for health care services determined to be medically necessary and appropriate for treatment of a compensable injury.

(10) HMO--A health maintenance organization licensed and regulated under Insurance Code Chapter 843.

(11) Independent review--A system for final administrative review by an independent review organization of the medical necessity and appropriateness of health care services being provided, proposed to be provided, or that have been provided to an employee.

(12) Independent review organization--An entity that is certified by the commissioner to conduct independent review under Insurance Code Article 21.58C and rules adopted by the commissioner.

(13) Life-threatening--Has the meaning assigned by Insurance Code Article 21.58A §2.

(14) Live--Where an employee lives includes:

(A) the employee's principal residence for legal purposes, including the physical address which the employee represented to the employer as the employee's address;

(B) a temporary residence necessitated by employment; or

(C) a temporary residence taken by the employee primarily for the purpose of receiving necessary assistance with routine daily activities because of a compensable injury.

(15) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(16) Medical records--The history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee.

(17) Mental health emergency--A condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(18) Network or workers' compensation health care network--An organization that is:

(A) formed as a health care provider network to provide or arrange to provide health care services to injured employees;

(B) required to be certified in accordance with Insurance Code Chapter 1305, this chapter, and other rules of the commissioner as applicable; and

(C) established by, or operating under contract with, an insurance carrier.

(19) Nurse--Has the meaning assigned by Insurance Code Article 21.58A §2.

(20) Occupational medicine specialist--A doctor who has received a board certification in occupational medicine from the American Board of Preventive Medicine or who has completed all the requirements of the American Board of Preventive Medicine in order to take the board examination.

(21) Person--Any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, or limited liability partnership.

(22) Preauthorization--The process required to request approval from the insurance carrier or the network to provide a specific treatment or service before the treatment or service is provided.

(23) Provider--A health care provider.

(24) Quality improvement program--A system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(25) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(26) Routine daily activities--Activities a person normally does in daily living, including sleeping, eating, bathing, dressing, grooming, and homemaking.

(27) Rural area--

(A) a county with a population of 50,000 or less;

(B) an area that is not designated as an urbanized area by the United States Census Bureau; or

(C) any other area designated as rural under rules adopted by the commissioner.

(28) Screening criteria--The written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review or retrospective review.

(29) Service area--A geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(30) Texas Workers' Compensation Act--Labor Code Title 5 Subtitle A.

(31) Transfer of risk--For purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(32) Utilization review--Has the meaning assigned by Insurance Code Article 21.58A §2.

(33) Utilization review agent--Has the meaning assigned by Insurance Code Article 21.58A §2.

(b) In this chapter, the following terms have the meanings assigned by Labor Code §401.011:

(1) administrative violation;

(2) case management;

(3) compensable injury;

(4) doctor;

(5) employer;

(6) evidence-based medicine;

(7) health care;

(8) health care facility;

(9) health care practitioner;

(10) health care provider;

(11) injury;

(12) insurance carrier; and

(13) treating doctor.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. CERTIFICATION

28 TAC §§10.20 - 10.27

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.20. Certification Required.

Except as provided by Labor Code §504.053(b)(2):

(1) A person may not operate or perform any act of a workers' compensation health care network in this state:

(A) unless the person holds a certificate issued under Insurance Code Chapter 1305 and this chapter, or

(B) except in accordance with the specific authorization of Insurance Code Chapter 1305 or this chapter.

(2) A person, including an insurance carrier, who provides or arranges to provide workers' compensation health care network services to injured employees within a service area by contracting with more than one person, must be certified as a workers' compensation health care network under Insurance Code Chapter 1305 and this chapter.

(3) An entity performing any act of a workers' compensation health care network may not use in a network's name or in any informational literature distributed about a network any combination or variation of the words "workers' compensation," "certified," "managed care," or "network" to describe a network that is not certified in accordance with this chapter.

§10.21. Certificate Application.

(a) A person who seeks a certificate to operate as a workers' compensation health care network must file an application on the forms prescribed under this subchapter, accompanied by a non-refundable fee of $5,000.

(b) The applicant, an officer, or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.

(c) Prescribed forms for a certificate application may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§10.22. Contents of Application.

Each certificate application must include:

(1) a description or a copy of the applicant's basic organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) a completed biographical affidavit adopted by reference under §7.507(b) of this title (relating to Forms Incorporated by Reference) from each person who governs or manages the affairs of the applicant, including the members of the governing board of the applicant, the chief executive officer, president, secretary, treasurer, chief financial officer and controller, and any other individuals with substantially similar responsibilities, provided that a biographical affidavit is not required if a biographical affidavit from the person is already on file with the department;

(3) a copy of the form of any contract between the applicant and any provider or group of providers as required under Insurance Code §§1305.151 - 1305.155 and §10.41 and §10.42 of this chapter (relating to Network-Carrier Contracts and Network Contracts with Providers);

(4) a copy of any agreement with any third party performing delegated functions on behalf of the applicant as required under Insurance Code §1305.154 and §10.41(a)(1) of this chapter;

(5) a copy of the form of each contract with an insurance carrier, as described by Insurance Code §1305.154 and §10.41 of this chapter;

(6) each management contract as described in §10.40 of this chapter (relating to Management Contracts), if applicable;

(7) a financial statement, current as of the date of the application that includes the most recent calendar quarter, prepared using generally accepted accounting principles, and including:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(8) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action arising in this state is valid if served in the manner provided by Insurance Code Chapter 804 for a domestic company;

(9) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county, ZIP code, partial ZIP code, or part of a county to be served;

(10) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Insurance Code §§1305.401 - 1305.405 and Subchapter G of this chapter (relating to Complaints);

(B) a quality improvement program, including return-to-work and medical case management programs, as required under Insurance Code §§1305.301 - 1305.304 and §10.81 of this chapter (relating to Quality Improvement Program);

(C) credentialing policies and procedures required under §10.82 of this chapter (relating to Credentialing);

(D) the utilization review and retrospective review programs described in Insurance Code §§1305.351 - 1305.355 and Subchapter F of this chapter (relating to Utilization Review and Retrospective Review), if applicable; and

(E) criteria and procedures for employees to select or change the employee's treating doctor, including procedures for employees to select as the employee's treating doctor a doctor who the employee selected, prior to injury, as the employee's HMO primary care physician or provider;

(11) a description of the network configuration that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate compliance with the access and availability standards under Insurance Code §§1305.301 - 1305.304 and §10.80 of this chapter (relating to Accessibility and Availability Requirements). This description shall include, at a minimum, the following:

(A) names; addresses, including ZIP codes; specialty or specialties; board certifications, if any; professional license numbers; and hospital affiliations of network providers, including treating doctors, in sufficient number and specialty to provide all required health care services in a timely, effective, and convenient manner;

(B) names; addresses; federal employer identification number (FEIN); licenses; and types of health care facilities, including hospitals, rehabilitation facilities, diagnostic and testing facilities, ambulatory surgical centers, and interdisciplinary pain rehabilitation programs or interdisciplinary pain rehabilitation treatment facilities. The network must also demonstrate adequate access to emergency care;

(C) information indicating whether each network provider is accepting new patients from the workers' compensation health care network; and

(D) information indicating which network doctors are trained and certified to perform maximum medical improvement determinations and impairment rating services;

(12) the physical location of the applicant's books and records, including:

(A) financial and accounting records;

(B) investment records;

(C) organizational documents of the applicant; and

(D) minutes of all meetings of the applicant's governing board and executive or management committees;

(13) a business plan that describes the applicant's intended operations in this state, including both a narrative description and projections related to anticipated revenue and profitability for the first two years of operation after certification;

(14) a completed financial authorization form sufficient to allow the department to confirm directly with appropriate financial institutions the reported assets of the applicant, unless the entity is already licensed by the department;

(15) the applicant's plan for provision of care to injured employees who live temporarily outside the service area, if applicable;

(16) the applicant's plan for provision of maximum medical improvement determinations and impairment rating services, including verification that the network doctors reported under paragraph (11)(D) of this section have completed the training required under Labor Code §408.023;

(17) the applicant's plan for obtaining certification by doctors and health care practitioners of filing the required financial disclosure with the division of workers' compensation under Labor Code §408.023 and §413.041;

(18) the form of the notice of network requirements and employee information, and the acknowledgment form required under Insurance Code §1305.005 and §10.60 of this chapter (relating to Notice of Network Requirements; Employee Information);

(19) the applicant's plan for monitoring whether providers have been provided and are following treatment guidelines, return-to-work guidelines, and individual treatment protocols as required under Insurance Code §1305.304 and §10.83 of this chapter (relating to Guidelines and Protocols);

(20) a description of treatment guidelines and return-to-work guidelines, and the network medical director's certification that the guidelines are evidence-based, scientifically valid, and outcome-focused as required under Insurance Code §1305.304 and §10.83(a) of this chapter; and

(21) a certification that:

(A) the network's medical director is an occupational medicine specialist; or

(B) the network employs or contracts with an occupational medicine specialist.

§10.24. Network Financial Requirements.

(a) On at least a calendar year basis, each network shall prepare financial statements in accordance with generally accepted accounting principles which must include:

(1) a balance sheet;

(2) an income statement;

(3) a cash flow statement;

(4) a statement of equity; and

(5) a supplemental description of the network's basic organizational structure, general business relationships, and management.

(b) On or before April 1st of each year, each network shall provide the network's financial statement required by subsection (a) of this section to:

(1) each carrier with which the network contracts to facilitate carrier and network compliance under Insurance Code §1305.154(c) and §1305.155 and §10.41 of this chapter (relating to Network-Carrier Contracts); and

(2) the department by sending the financial statement to the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§10.25. Filing Requirements.

(a) A network shall file with the department as soon as practicable but not later than 30 days prior to implementation, a written request for approval and must receive department approval before implementation of changes to the following:

(1) management contracts and information regarding fidelity bonds as described in Insurance Code §1305.102, including information regarding cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds;

(2) the physical location of the network's books and records as described in §10.22(12) of this subchapter (relating to Contents of Application);

(3) material modification of network configuration; and

(4) expansion, elimination, or reduction of an existing service area, or addition of a new service area.

(b) A network shall file with the department any information other than the information in subsection (a) of this section that amends, supplements, or replaces the items required under §10.22 of this subchapter. The information must be filed no later than 30 days after implementation of any change.

§10.26. Modifications to Service Area.

(a) A network must file a modification request with and receive approval from the department before the network may expand, eliminate, or reduce an existing service area, or add a new service area. The modification request must be filed not later than 30 days before implementation of the modification. An officer or other authorized representative of the network must verify the modification request by attesting to the truth and accuracy of the information in the modification request.

(b) A modification request for a service area modification must include:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area, as required under §10.22(9) of this subchapter (relating to Contents of Application);

(2) network configuration information, as required under §10.22(11) of this subchapter; and

(3) separate and consolidated projections as described in §10.22(13) of this subchapter for the existing network, the proposed new service area, and the proposed network.

(c) If a modification request for a service area changes any of the following items, the applicant must file the new item or any amendments to an existing item with the modification request filed under this section:

(1) a copy of the form of any new contracts or amendment of any existing contracts as described by and required under §10.22(3), (4) and (5) of this subchapter;

(2) a brief narrative description of the administrative arrangements, organizational charts as required under §10.22(1) of this subchapter, and other pertinent information;

(3) biographical data, on a form prescribed by the department, regarding each individual who governs or manages the affairs of the network as required under §10.22(2) of this subchapter; and

(4) a copy of each management contract as described under §10.22(6) of this subchapter.

(d) A modification request is not considered complete and reviewable until the department has received all information required under this section, including any additional information the department requests as needed to make that determination.

(e) Before the department considers a service area modification request, the applicant must be in good standing with the department and in compliance with all applicable requirements under this chapter, Insurance Code Chapter 1305, and Labor Code Title 5 in the existing service areas and in each proposed service area.

(f) A corrected notice of network requirements and employee information and acknowledgment form must be provided to affected employees.

(g) Prescribed modification request forms may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§10.27. Modifications to Network Configuration.

(a) A network must file a modification request with and receive approval from the department before the network makes a material modification to its network configuration. The modification request must be filed not later than 30 days prior to implementation of the material modification.

(b) A modification request for a modification to network configuration must include:

(1) a description and a map of the network's service area or areas, with key and scale, that identifies each county, ZIP code, partial ZIP code, or part of a county to be served as required by §10.22 of this subchapter (relating to Contents of Application); and

(2) network configuration information, as required by §10.22(11) of this subchapter.

(c) The applicant must file a copy of the form of any new contracts or amendment of any existing contracts as described by and required under §10.22(3), (4) and (5) of this subchapter if the modification of network configuration causes changes.

(d) A modification request is not considered complete and reviewable until the department has received all information required under this section, including any additional information the department requests as needed to make the determination.

(e) Before the department considers a modification request to modify a network's configuration, the applicant must be in good standing with the department and in compliance with all applicable requirements under this chapter, Insurance Code Chapter 1305, and Labor Code Title 5.

(f) Prescribed modification request forms may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 15, 2005.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 5, 2005
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For further information, please call: (512) 463-6327

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SUBCHAPTER C. CONTRACTING

28 TAC §§10.40 - 10.42

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the

Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.40. Management Contracts.

(a) A network may not enter into a contract with another entity for management services, or modify a previously approved management contract, unless the proposed contract or modification is first filed with the department and approved by the commissioner in accordance with Insurance Code §1305.102.

(b) For purposes of this chapter, management services include management control and decision-making, and contracting on behalf of the network under a delegation of management authority, power of attorney or other arrangement.

§10.41. Network-Carrier Contracts.

(a) A network's contract with a carrier shall include the following:

(1) a description of the functions to be performed by the network or its delegated entity, consistent with the requirements of Insurance Code §1305.154(b), and the reporting requirements for each function;

(2) a statement that the network will perform all delegated functions in full compliance with all requirements of the Workers' Compensation Health Care Network Act, Insurance Code Chapter 1305, the Texas Workers' Compensation Act, Labor Code Title 5 Subtitle A and rules of the commissioner or the commissioner of workers' compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either party without 90 days' prior written notice; and

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any amounts from an employee for health care services for compensable injuries under any circumstances, including the insolvency of the carrier or the network;

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules, and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services listed in Insurance Code §1305.154(b) as well as any other services or functions the carrier delegates, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, on at least a monthly basis and in a form that is usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation of the department with respect to any services provided pursuant to the carrier-network contract, including the following data:

(A) last name, first name, date of injury, date of birth, sex, address, telephone number and social security number of each injured employee who is being served by the network, and name and license number of the injured employee's treating doctor;

(B) initial date of health care services delivered by the network for each employee; and

(C) any other data, as determined by the contract, necessary to assure proper monitoring of functions delegated to the network by the carrier;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with a provision that requires the network to provide to the insurance carrier and department the license number of a management contractor or any delegated third party performing any function that requires a license under the Insurance Code or another insurance law of this state, including a license as a utilization review agent under Insurance Code Article 21.58A;

(9) a contingency plan under which the carrier would, in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payment to providers and notification to employees, as applicable;

(B) quality of care;

(C) utilization review;

(D) retrospective review;

(E) continuity of care, including a plan for identifying and transitioning employees to new providers; and

(F) collecting and reporting of data necessary to comply with the reporting requirements described in paragraph (7) of this subsection;

(10) a provision that requires that any agreement by which the network delegates any function to a third party be in writing, and that such agreement require the delegated third party to be subject to all the requirements under Insurance Code Chapter 1305 and this chapter;

(11) a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party performing any function that requires a license under the Insurance Code or another insurance law of this state, including a license as a utilization review agent under Insurance Code Article 21.58A;

(12) an acknowledgement that:

(A) any management contractor or third party to whom the network delegates a function must comply with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or third party fails to meet monitoring standards established to ensure that functions delegated or assigned to the management contractor or third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or network may cancel delegation of any or all delegated functions;

(13) a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information to allow the carrier to provide the infor-

mation required by §10.60 of this chapter (relating to Notice of Network Requirements; Employee Information) to employers or employees;

(14) a provision that requires the network to require any third party with which it contracts, whether directly or through another third party, to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

(15) a requirement that the network:

(A) implement and maintain a complaint system in accordance with requirements under Insurance Code §1305.401 and §10.120 of this chapter (relating to Complaint System Required); and

(B) make the complaint log and complaint files available to the carrier upon request to the extent permitted by law;

(16) a statement that the contract and any network contract with a provider, management contractor or other third party shall not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26);

(17) a statement that any network contract with a provider or third party must allow the carrier to effect a contingency plan in the event that the carrier is required to reassume functions from the network as contemplated under Insurance Code §1305.155; and

(18) a statement that any network contract with a provider or third party must comply with all applicable statutory and regulatory requirements under federal and state law.

(b) Except for the functions described under Insurance Code §1305.154(b) and §10.121 of this chapter (relating to Complaints; Deadlines for Responses and Resolution), a network's authority to perform a function under a network-carrier contract is conditioned upon whether:

(1) the carrier has delegated the function to the network by contract; and

(2) the network is appropriately licensed to perform the function.

(c) A network shall not act as a network for any entity regarding an insurance plan which is being operated in violation of Insurance Code §101.102.

§10.42. Network Contracts with Providers.

(a) A network is not required to accept an application for participation in the network from a health care provider that otherwise meets the requirements specified in this chapter if the network determines that the network has contracted with a sufficient number of qualified health care providers, including health care providers of the same license type or specialty.

(b) Provider contracts and subcontracts shall include, at a minimum, the following provisions:

(1) except as provided in Insurance Code §1305.451(b)(6), a hold-harmless clause stating that the provider and the provider network will not bill or attempt to collect any amounts of payment from an employee for health care services for compensable injuries under any circumstances, including the insolvency of the insurance carrier or the network;

(2) a statement that the provider agrees to follow treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by the network pursuant to §10.83 of this chapter (relating to Guidelines and Protocols), as applicable to an employee's injury;

(3) a statement that the insurance carrier or network may not deny treatment solely on the basis that a treatment for a compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network;

(4) a provision that the network will not engage in retaliatory action, including termination of or refusal to renew a contract, against a provider because the provider has, on behalf of an employee, reasonably filed a complaint against, or appealed a decision of, the network, or requested reconsideration or independent review of an adverse determination;

(5) a continuity of treatment clause that states that:

(A) if a provider leaves the network, upon the provider's request, the insurance carrier or network is obligated to continue to reimburse the provider for a period not to exceed 90 days at the contracted rate for care of an employee with a life-threatening condition or an acute condition for which disruption of care would harm the employee; and

(B) a dispute concerning continuity of care shall be resolved through the complaint resolution process under Insurance Code §§1305.401 - 1305.405 and Subchapter G of this chapter (relating to Complaints);

(6) a clause regarding appeal by the provider of termination of network provider status, except for termination due to contract expiration, and applicable written notification to employees receiving care regarding such a termination, including requirements that:

(A) the network must provide notice to the provider at least 90 days before the effective date of a termination.

(B) the network must provide an advisory review panel that consists of at least three providers of the same licensure and the same or similar specialty as the provider;

(C) upon receipt of the written notification of termination, a provider may request a review by the network's advisory review panel not later than 30 days after receipt of the notification;

(D) the network must complete the advisory panel review before the effective date of the termination;

(E) a network may not notify patients of the termination until the earlier of the effective date of the termination or the date the advisory review panel makes a formal recommendation;

(F) in the case of imminent harm to patient health, suspension or loss of license to practice, or fraud, the network may terminate the provider immediately and must notify employees immediately of the termination; and

(G) if the provider terminates the contract, the network must provide notification of the termination to employees receiving care from the terminating provider. The network shall give such notice immediately upon receipt of the provider's termination request or as soon as reasonably possible before the effective date of termination;

(7) a provision that requires the provider to post, in the office of the provider, a notice to employees on the process for resolving workers' compensation health care network complaints in accordance with Insurance Code §1305.405. The notice must include the department's toll-free telephone number for filing a complaint and must list all workers' compensation health care networks with which the provider contracts;

(8) a statement that the network agrees to furnish to the provider, and the provider agrees to abide by, the list of any treatments and services that require the network's preauthorization and any procedures to obtain preauthorization;

(9) a statement that the contract and any subcontract within the provider network shall not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26);

(10) a statement that the provider and any subcontracting provider within the provider network must comply with all applicable statutory and regulatory requirements under federal and state law;

(11) the schedule of fees that will be paid to the contracting provider;

(12) a statement specifying whether the provider whose specialty has been designated by the network as a treating doctor agrees to be a network treating doctor and, if so, any additional provisions applicable to the provider;

(13) a statement that billing by and payment to the provider will be made in accordance with Labor Code §408.027 and other applicable statutes and rules; and

(14) a statement that the provider specifically agrees to provide treatment for injured employees who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

(c) An insurance carrier and a network may not use any financial incentive or make a payment to a health care provider that acts directly or indirectly as an inducement to limit medically necessary services. The adoption of treatment guidelines, return-to-work guidelines, and individual treatment protocols by a network under Insurance Code §1305.304 and §10.83(a) of this chapter (relating to Guidelines and Protocols) is not a violation of this section.

(d) An insurance carrier or a network must provide written notice to a network provider or group of network providers before the carrier or network conducts economic profiling, including utilization management studies comparing the provider to other providers, or other profiling of the provider or group of providers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 15, 2005.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER D. NETWORK REQUIREMENTS

28 TAC §§10.60 - 10.63

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.60. Notice of Network Requirements; Employee Information.

(a) An insurance carrier that establishes or contracts with a network shall deliver to the employer, and the employer shall deliver to the employer's employees in the manner and at the times prescribed by Insurance Code §1305.005:

(1) the notice of network requirements and employee information required by Insurance Code §1305.005 and §1305.451 and this section; and

(2) the employee acknowledgment form described by Insurance Code §1305.005 and this section.

(b) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor or request a doctor who the employee selected, prior to the injury, as the employee's HMO primary care physician or provider, upon notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Insurance Code §1305.451. The notice must include an employee acknowledgement form and comply with all requirements under subsections (c) - (h) of this section, as applicable.

(c) The notice of network requirements and employee acknowledgment form:

(1) must be in English, Spanish, and any other language common to 10 percent or more of the employer's employees;

(2) must be in a readable and understandable format that meets the plain language requirements under §10.63 of this subchapter (relating to Plain Language Requirements); and

(3) may be in an electronic format provided a paper version is available upon request.

(d) The insurance carrier and employer may use:

(1) an employee acknowledgment form that complies with this section; or

(2) a sample acknowledgment form that may be obtained from:

(A) the department's website at www.tdi.state.tx.us; or

(B) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(e) The employee acknowledgment form must include:

(1) a statement that the employee has received information that describes what the employee must do to receive health care under workers' compensation insurance;

(2) a statement that if the employee is injured on the job and lives in the service area described in the information, the employee understands that:

(A) the employee:

(i) must select a treating doctor from the list of doctors who contracted with the workers' compensation network, or

(ii) ask the employee's HMO primary care physician to agree to serve as the employee's treating doctor; and

(iii) must obtain all health care and specialist referrals for a compensable injury through the treating doctor except for emergency services;

(B) the network provider will be paid by the insurance carrier and will not bill the employee for a compensable injury; and

(C) if the employee seeks health care, other than emergency care, from someone other than a network provider without network approval, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(3) separate lines for the employee to fill in the date and employee's signature, printed name and where the employee lives;

(4) a separate line that indicates the name of the employer; and

(5) a separate line that indicates the name of the network.

(f) The employer shall obtain a signed employee acknowledgment form from each employee, and a carrier required to provide employee information to an employee under Insurance Code §1305.103(c) and subsection (b) of this section shall obtain a signed employee acknowledgment form from that employee. For purposes of this subsection, an employer or carrier, as applicable, may obtain an acknowledgement of the notice required under this section through electronic means from an employee who makes an electronic signature in accordance with applicable law.

(g) The notice of network requirements must comply with Insurance Code §1305.005 and §1305.451 and include:

(1) a statement that the entity providing health care to employees is a certified workers' compensation health care network;

(2) the network's toll-free number and address for obtaining additional information about the network, including information about network providers;

(3) a description and map of the network's service area, with key and scale, that clearly identifies each county or ZIP code area or any parts of a county or ZIP code area that are included in the service area;

(4) a statement that an employee who does not live within the network's service area may notify the carrier as described under §10.62 of this subchapter (relating to Dispute Resolution for Employee Requirements Related to In-Network Care);

(5) a statement that an employee who asserts that he or she does not currently live in the network's service area may choose to receive all health care services from the network during the pendency of the insurance carrier's review under §10.62 of this subchapter and the pendency of the department's review of a complaint; and the employee may be liable, and the carrier may not be liable, for payment for health care services received out of network if it is ultimately determined that the employee lives in the network's service area;

(6) a statement that, except for emergency services, the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(7) an explanation that network providers have agreed to look only to the network or insurance carrier and not to employees for payment of providing health care for a compensable injury, except as provided by paragraph (8) of this subsection;

(8) a statement that if the employee obtains health care from non-network providers without network approval, except for emergency care, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(9) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(10) a list of the health care services for which the insurance carrier or network requires preauthorization or concurrent review;

(11) an explanation regarding continuity of treatment in the event of the termination from the network of a treating doctor;

(12) a description of the network's complaint system, including:

(A) a statement that an employee must file complaints with the network regarding dissatisfaction with any aspect of the network's operations or with network providers;

(B) any deadline for the filing of complaints, provided that the deadline may not be less than 90 days after the date of the event or occurrence that is the basis for the complaint;

(C) a single point of contact within the network for receipt of complaints, including the address and e-mail address of the contact; and

(D) a statement that the network is prohibited from retaliating against:

(i) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(ii) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network; and

(E) a statement explaining how an employee may file a complaint with the department as described under §10.122 of this chapter (relating to Submitting Complaints to the Department);

(13) a summary of the insurance carrier's or network's procedures relating to adverse determinations and the availability of the independent review process;

(14) a list of network providers updated at least quarterly, including:

(A) the names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure listing which providers are accepting new patients; and

(15) a statement that, except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to an employee on a timely basis on request and within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 days after the date of the request.

(h) An employer or carrier, as applicable, shall deliver the notice of network requirements and acknowledgment form to the employer's employees and document the method of delivery, to whom the notice was delivered, the location of the delivery, and the date or dates of delivery. The failure of an employer or carrier, as applicable, to establish a standardized process for delivering to an employee a notice of network requirements and acknowledgment form for a network that has a service area in which the employee lives, including documentation of the method of delivery of the notice, to whom the notice was delivered, location of delivery, and the date or dates of delivery, creates a rebuttable presumption that the employee has not received the notice of network requirements and is not subject to network requirements.

§10.61. Employees Who Live Within the Network Service Area, Employee Access and Insurance Carrier Liability for Health Care.

(a) The employees of an employer who elects to contract with an insurance carrier for network health care services, and who live within the network's service area, are required to obtain medical treatment for a compensable injury within the network, except as provided in Insurance Code §1305.006(1) and (3) and subsection (f)(1), (3) and (4) of this section.

(b) An employee is presumed to live at the physical address he or she has represented to the employer as his or her address or, if the employee no longer works for the employer, the physical address of record on file with the insurance carrier.

(c) At any time after the receipt of the notice of network requirements, an employee who no longer lives at the physical address described in subsection (b) of this section, or who otherwise asserts that he or she does not live in the network's service area, may notify the insurance carrier and request a review under §10.62 of this subchapter (relating to Dispute Resolution for Employee Requirements Related to In-Network Care).

(d) An employee who does not live within a network's service area may choose to participate in a network established by the insurance carrier or with which the insurance carrier has a contract upon mutual agreement between the employee and insurance carrier.

(e) An employee who is found to have fraudulently claimed to live outside the network's service area or made an intentional misrepresentation regarding where he or she lives and receives health care outside the network's service area may be liable for payment for that health care.

(f) An insurance carrier that establishes or contracts with a network is liable for in-network health care for a compensable injury that is provided to an injured employee in accordance with Insurance Code Chapter 1305, and out-of-network care as follows:

(1) emergency care;

(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract;

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network as follows:

(A) if an injured employee's treating doctor requests a referral to an out-of-network provider for medically necessary health care services that are not available from network providers, the network shall approve or deny a referral to an out-of network provider within the time appropriate under the circumstances but, under any circumstance, not later than seven days after the date the referral is requested;

(B) if the network denies the referral request under subsection (a) of this section because the requested service is available from network providers, the employee may file a complaint in accordance with the network's complaint process under Insurance Code §1305.402 and §10.121 of this chapter (relating to Complaints; Deadlines for Response and Resolution);

(C) if the network denies the referral request under subparagraph (A) of this paragraph because the specialist referral is not medically necessary, the employee may file a request for independent review as described in §10.104 of this chapter (relating to Independent Review of Adverse Determination); and

(4) health care services provided to an injured employee before the employee received the notice of network requirements and the employee information for the appropriate network and service area under Insurance Code §1305.005 and §10.60 of this subchapter (relating to Notice of Network Requirements; Employee Information).

§10.62. Dispute Resolution for Employee Requirements Related to In-Network Care.

(a) If an employee asserts that he or she does not currently live in the network's service area, the employee may request a review by contacting the insurance carrier and providing evidence to support the employee's assertion.

(b) An insurance carrier shall review the employee's request for review, including any evidence provided by the injured employee and any evidence collected by the insurance carrier, and make a determination regarding whether the employee lives within the network's service area or lives within the service area of any other workers' compensation network contracted with or established by the insurance carrier (alternate network). If an insurance carrier makes a determination that the employee lives within the service area of an alternate network, the insurance carrier shall provide the employee with the notice of network requirements as described under §10.60 of this subchapter (relating to Notice of Network Requirements; Employee Information) for the alternate network. Upon receipt of the notice of network require-

ments, the employee must select a treating doctor from the list of the alternate network's treating doctors in the network's service area.

(c) Not later than seven calendar days after the date the insurance carrier receives notice of the injured employee's request for review, the insurance carrier shall notify the employee, in writing, of the carrier's determination. This notice shall include a brief description of the evidence the carrier considered when making the determination, a copy of the carrier's determination and a description of how an employee may file a complaint regarding this issue with the department. The insurance carrier shall also send a copy of the carrier's determination to the employee's employer.

(d) If an employee disagrees with the insurance carrier's determination, the employee may file a complaint with the department in accordance with §10.122 of this chapter (relating to Submitting Complaints to the Department). To be considered complete, the employee's complaint must include:

(1) the employee's contact information, including the employee's name, current physical address, and telephone number;

(2) a copy of the insurance carrier's determination; and

(3) any evidence the employee provided to the insurance carrier for consideration.

(e) An injured employee who disputes whether he or she lives within a network's service area may seek all medical care from the network during the pendency of the insurance carrier's review and the department's investigation of a complaint.

§10.63. Plain Language Requirements.

(a) The notice of network requirements and employee information form and acknowledgment form required by Insurance Code §1305.451 and §10.60 of this subchapter (relating to Notice of Network Requirements; Employee Information) shall be written in plain language and comply with the following requirements:

(1) the text shall achieve a minimum level of readability which may not be more difficult than the equivalent of a ninth grade reading level as measured by the Flesch reading ease test, a test referenced in the list of standardized tests contained in §3.3092(c)(1) of this title (relating to Format, Content, and Readability for Outline of Coverage), or other standardized test as approved by the department;

(2) the form shall be printed in not less than 12-point type;

(3) the form shall be appropriately divided and captioned in a meaningful sequence such that each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section; and

(4) the form shall be written in a clear and coherent manner and wherever practical, words with common and everyday meanings shall be used to facilitate readability.

(b) The notice of network requirements and employee information form described at §10.22(18) of this chapter (relating to Contents of Application) shall be filed with the department in accordance with §10.21 of this chapter (relating to Certificate Application) and shall be accompanied by a certification signed by an officer or other authorized representative of the network stating the reading level of the form, the standardized test utilized to determine the reading level, and that the form meets or exceeds the minimum readability standards established by the commissioner. To confirm the accuracy of any certification, the commissioner may require the submission of additional information.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. NETWORK OPERATIONS

28 TAC §§10.80 - 10.86

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.80. Accessibility and Availability Requirements.

(a) All services specified by this section must be provided by a provider who holds a current appropriate license, unless the provider is exempt from license requirements.

(b) The network shall ensure that the network's provider panel includes:

(1) an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area;

(2) sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees;

(3) an adequate number of the treating doctors and specialists who have admitting privileges at one or more network hospitals located within the network's service area to make any necessary hospital admissions;

(4) hospital services that are available and accessible 24 hours a day, seven days a week, within the network's service area. The network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals, as applicable;

(5) physical and occupational therapy services and chiropractic services that are available and accessible within the network's service area;

(6) emergency care that is available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered; and

(7) an adequate number of doctors who are qualified to provide maximum medical improvement and impairment rating services as required under Labor Code §408.023.

(c) Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to injured employees within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 calendar days after the date of the original request.

(d) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than:

(1) 30 miles in nonrural areas; and

(2) 60 miles in rural areas.

(e) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a specialist or specialty hospital is not greater than:

(1) 75 miles in nonrural areas; and

(2) 75 miles in rural areas.

(f) For portions of the service area in which the network or department identifies noncompliance with this section, the network must file an access plan with the department for approval at least 30 days before implementation of the plan if any health care service or a network provider is not available to an employee because:

(1) providers are not located within the required distances;

(2) the network is unable to obtain provider contracts after good faith attempts; or

(3) providers meeting the network's minimum quality of care and credentialing requirements are not located within the required distances.

(g) The access plan required under subsection (f) of this section must include:

(1) a description of the geographic area in which services or providers are not available, identified by county, city, ZIP code, mileage, or other identifying data;

(2) a map, with key and scale, which identifies the areas in which such health care services or providers are not available;

(3) for each geographic area identified as not having adequate health care services or providers available, the reason or reasons that health care services or providers cannot be made available;

(4) the network's general plan for making health care services and providers available to injured employees in each geographic area identified, including:

(A) the names, addresses and specialties of the network providers and a listing of the services to be provided through the network that meet the health care needs of the employees;

(B) a listing of any health care services to be made available in the geographic area;

(C) a general description of the procedures to be followed by the network to assure that certain health care services are made available and accessible to employees in the geographic areas identified as being areas in which the health care services or providers are not available and accessible; and

(D) a network development plan through which health care services or providers will be made available and accessible to employees in these geographic areas in the future;

(5) any other information which is necessary to allow the department to assess the network's access plan.

(h) The network may make arrangements with providers outside the service area to enable employees to receive skilled or specialty care not available within the network service area.

(i) The network is not required to expand services outside the network's service area to accommodate employees who live outside the service area.

§10.81. Quality Improvement Program.

(a) A network shall develop and maintain a continuous and comprehensive quality improvement program designed to monitor and evaluate objectively and systematically the quality and appropriateness of health care and network services, and to pursue opportunities for improvement. The quality improvement program shall include return-to-work and medical case management programs. The network shall dedicate adequate resources, including personnel and information systems, to the quality improvement program.

(b) Required documentation of the quality improvement program, at a minimum, includes:

(1) Written description. The network shall develop a written description of the quality improvement program that outlines program organizational structure, functional responsibilities, and committee meeting frequency;

(2) Work plan. The network shall develop an annual quality improvement work plan designed to reflect the type of services and the population served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry. The work plan shall include:

(A) objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, individuals responsible, and evaluation methodology;

(B) evaluation of each program, including:

(i) network adequacy, which encompasses availability and accessibility of care and assessment of providers who are and are not accepting new patients;

(ii) continuity of health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of treatment guidelines, return-to-work guidelines, individual treatment protocols and the list of services requiring preauthorization;

(v) employee and provider satisfaction;

(vi) the complaint and appeal process, complaint data, and identification and removal of communication barriers which may impede employees and providers from effectively making complaints against the network;

(vii) provider billing and provider payment processes, if applicable;

(viii) contract monitoring, including delegation oversight, if applicable, and compliance with filing requirements;

(ix) utilization review and retrospective review processes, if applicable;

(x) credentialing;

(xi) employee services, including after-hours telephone access logs;

(xii) return-to-work processes and outcomes; and

(xiii) medical case management outcomes.

(3) Annual evaluation. The network shall prepare an annual written report on the quality improvement program, which includes:

(A) completed activities;

(B) trending of clinical and service goals;

(C) analysis of program performance; and

(D) conclusions regarding the effectiveness of the program.

(c) The network is presumed to be in compliance with statutory and regulatory requirements regarding quality improvement requirements, including credentialing, if:

(1) the network has received nonconditional accreditation or certification by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Accreditation HealthCare Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC);

(2) the accreditation includes all quality improvement requirements set forth in this section;

(3) the certification for a function, including credentialing, includes all requirements set forth in this section; and

(4) the national accreditation organization's requirements are the same, substantially similar to, or more stringent than the department's quality improvement requirements.

(d) The network governing body is ultimately responsible for the quality improvement program and shall:

(1) appoint a quality improvement committee that includes network providers;

(2) approve the quality improvement program;

(3) approve an annual quality improvement work plan;

(4) meet no less than annually to receive and review reports of the quality improvement committee or group of committees, and take action when appropriate; and

(5) review the annual evaluation of the quality improvement program.

(e) The quality improvement committee shall evaluate the overall effectiveness of the quality improvement program. The committee may delegate and oversee quality improvement activities to subcommittees that may, if applicable, include practicing doctors and employees from the service area. All subcommittees shall:

(1) collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services; and

(2) meet regularly and routinely report findings, recommendations, and resolutions in writing to the quality improvement committee for the network.

(f) The network shall have a medical case management program with certified case managers whose certifying organization must be accredited by an established accrediting organization, including the National Commission for Certifying Agencies (NCCA), the American Board of Nursing Specialties, or another national accrediting agency with similar standards. In accordance with Labor Code §413.021(a), a claims adjuster may not serve as a case manager. The case manager shall work with providers, employees, doctors and employers to facilitate cost-effective health care and the employee's return to work, and must be certified in one or more of the following areas:

(1) case management;

(2) case management administration;

(3) rehabilitation case management;

(4) continuity of care;

(5) disability management; or

(6) occupational health.

(g) Until January 1, 2007, non-certified case managers may assist in providing the required medical case management services. The non-certified case managers must have prior experience in one of the areas delineated in subsection (f)(1) - (6) of this section, and may not serve as claim adjusters. The non-certified case managers must be under the direct supervision of a certified case manager as described in subsection (f) of this section at all times.

§10.82. Credentialing.

(a) Process for selection and retention of network doctors and health care practitioners.

(1) A network shall implement a documented process for selection and retention of contracted doctors and health care practitioners including the following elements, as applicable:

(A) The network's policies and procedures shall clearly indicate the doctor or health care practitioner directly responsible for the credentialing program and shall include a description of his or her participation.

(B) Networks shall develop written criteria for credentialing of doctors and health care practitioners and written procedures for verifications. Procedures shall include certification by applicants of completion of required maximum medical improvement and impairment rating training and filing of financial disclosure in accordance with Labor Code §408.023 and §413.041. The credentialing criteria and procedures must be made available to network providers or applicants upon request.

(i) The network shall credential all doctors and health care practitioners, including advanced practice nurses and physician assistants, if they are listed in the provider directory. A network shall credential each doctor and health care practitioner who is a member of a contracting group, such as an independent doctor association or medical group.

(ii) The network's policies and procedures must include the following doctors' and health care practitioners' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) A network is not required to credential:

(I) hospital-based doctors or health care practitioners, including advanced practice nurses and physician assistants, unless listed in the provider directory;

(II) health care practitioners who furnish services only under the direct supervision of a doctor or another health care practitioner except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) A network must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the doctor or health care practitioner.

(v) The network's policies and procedures shall include a provision that applicants be notified of the credentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) A network must have written policies and procedures for suspending or terminating affiliation with a contracting doctor or health care practitioner.

(vii) The network shall have a procedure for the ongoing monitoring of doctor and health care practitioner performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: The network must determine the publication schedule or release dates applicable to its doctor and health care practitioner community; the network is responsible for reviewing the information within 30 calendar days of its release;

(II) information from state licensing boards regarding sanctions or licensure limitations;

(III) complaints; and

(IV) information from the department's division of workers' compensation regarding sanctions or practice limitations.

(viii) The network's procedures shall ensure that selection and retention criteria do not discriminate against doctors or health care practitioners who serve high-risk populations. Procedures shall also include a provision that credentialing and recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or types of patients.

(I) The network shall have a procedure for notifying licensing or other appropriate authorities, including the department's division of workers' compensation, when a doctor's or health care practitioner's affiliation is suspended or terminated due to quality of care concerns.

(II) The network shall maintain evidence of notification as required under subclause (I) of this clause.

(C) The initial credentialing process for doctors and health care practitioners must include the following:

(i) Doctors and health care practitioners shall complete an application which includes a work history covering at least the immediately preceding five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, current use of illegal drugs, current professional liability insurance coverage information, and information on whether the doctor or health care practitioner will accept new patients from the network. A network may use the standardized credentialing application form specified in §21.3201 of this title (relating to Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) for credentialing of health care practitioners. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for initial credentialing.

(ii) The network shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the doctor's or health care practitioner's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the doctor or health care practitioner indicates that he/she is board certified on the application. The network may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association Master-

File, or from the specialty boards, and the network must use the most recent available source.

(IV) A valid DEA or DPS Controlled Substances Registration Certificate, if applicable, in effect at the time of the credentialing decision. The network may verify the certificate(s) by any one of the following means:

(-a-) a copy of the DEA or DPS certificate;

(-b-) visual inspection of the original certificate;

(-c-) confirmation with DEA or DPS;

(-d-) confirmation of entry in the National Technical Information Service database; or

(-e-) confirmation of entry in the American Medical Association Physician MasterFile.

(iii) The network shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the doctor's or health care practitioner's credentialing file the following:

(I) past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the doctor or health care practitioner, which the network may obtain from the professional liability carrier or the National Practitioner Data Bank; and

(II) information on previous sanction activity by Medicare and Medicaid which the network may obtain from one of the following:

(-a-) National Practitioner Data Bank;

(-b-) Cumulative Sanctions Report available over the internet;

(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting networks;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General; or

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The network shall perform a site visit to the offices of each treating doctor as part of the initial credentialing process. If doctors or health care practitioners are part of a group practice that shares the same office, the network may perform one visit to the site for all doctors or health care practitioners in the group practice, as well as for new doctors or health care practitioners who subsequently join the group practice. The network shall make the site visit assessment available to the department for review. The network shall have a process to track the relocation of and the opening of additional office sites for treating doctors as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the network. If a treating doctor offers services that require certification or licensure, such as laboratory or radiology services, the treating doctor shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the network shall determine whether the site conforms to the network's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the network's standards, the network shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(vi) A network may phase in the required site visits to treating doctors until not later than the first anniversary after the date of the network's certification. If the department receives a complaint about a treating doctor who has not had a site visit, the network shall perform a site visit not later than 30 days after notification by the department of the complaint unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found.

(D) The network shall have written procedures for recredentialing doctors and health care practitioners at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current use of illegal drugs;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for recredentialing and shall include the following processes:

(I) reverification of the following from the primary sources:

(-a-) licensure and information on sanctions or limitations on licensure;

(-b-) board certification:

(-1-) if the doctor or health care practitioner was due to be recertified; or

(-2-) if the doctor or health care practitioner indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. The network may reverify the certificate(s) by any one of the following means:

(-1-) a copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) confirmation of entry in the National Technical Information Service database; or

(-5-) confirmation of entry in the American Medical Association Physician MasterFile;

(II) review of updated history of professional liability claims in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for health care facilities shall include the following:

(i) evidence of state licensure;

(ii) evidence of Medicare certification;

(iii) evidence of compliance with other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from the Texas Department of State Health Services or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) evidence of accreditation by a national accrediting body, as applicable; the network shall determine which national accrediting bodies are appropriate for different types of health care facilities. The network's written policies and procedures must state which national accrediting bodies it accepts; and

(v) evidence of on-site evaluation of the health care facility against the network's written standards for participation if the provider is not accredited by the national accrediting body required by the network.

(F) The network procedures shall provide for recredentialing of health care facilities at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (v) of this paragraph.

(2) The network or the network's delegated entity shall make all credentialing processes and files available to the department upon request.

(b) Site visits for cause.

(1) The network shall have procedures for detecting deficiencies subsequent to the initial site visit. When the network identifies new deficiencies, the network shall reevaluate the site and institute actions for improvement.

(2) A network may conduct a site visit to the office of any doctor or health care practitioner at any time for cause. The network shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(c) Peer review. The quality improvement program shall provide for a peer review procedure for doctors, as required under the Medical Practice Act, Chapters 151 - 164, Occupations Code. The network shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(d) Delegation of credentialing.

(1) If the network delegates credentialing functions to other entities, it shall have:

(A) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(B) a delegation agreement;

(C) a monitoring plan; and

(D) a procedure for termination of the delegation agreement for non-performance.

(2) If the network delegates credentialing functions to an entity accredited by one of the national accreditation organizations as described in §10.81(c) of this subchapter (relating to Quality Improvement Program), the annual audit of that entity is not required for the function(s) listed in the accreditation; however, evidence of this accreditation shall be made available to the department for review.

(3) The network shall maintain and shall make available for the department to review:

(A) documentation of pre-delegation and annual audits;

(B) executed delegation agreements;

(C) semi-annual reports received from the delegated entities;

(D) evidence of evaluation of the reports;

(E) current rosters or copies of signed contracts with doctors and health care practitioners who are affected by the delegation agreement; and

(F) documentation of ongoing monitoring.

(4) Credentialing files maintained by the other entities to which the network has delegated credentialing functions shall be made available to the department for examination upon request.

(5) In all cases, the network shall maintain the right to approve credentialing, suspension, and termination of doctors and health care practitioners.

§10.83. Guidelines and Protocols.

(a) Each network shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols, which must be evidence-based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary health care while safeguarding access to necessary care.

(b) An insurance carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury.

(c) A network shall, through its quality improvement program under §10.81 of this subchapter (relating to Quality Improvement Program), assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all network providers. The network shall contractually require providers to follow treatment guidelines, return-to-work guidelines and individual treatment protocols pursuant to §10.42(b)(2) of this chapter (relating to Network Contracts with Providers).

§10.85. Selection of Treating Doctor; Change of Treating Doctor.

(a) Selection of treating doctor. An injured employee who lives within the service area is entitled to the employee's initial choice of a treating doctor from the list provided by the network of all treating doctors under contract with the network who provide services within the service area in which the injured employee lives in accordance with Insurance Code §1305.104(a).

(b) Change of treating doctor. An injured employee who is dissatisfied with the employee's initial choice of treating doctor or with an alternate treating doctor may select an alternate or subsequent treating doctor in accordance with Insurance Code §1305.104(b) - (e).

(c) Use of specialist as treating doctor. An injured employee with a chronic, life-threatening injury or chronic pain related to a compensable injury may apply to the network's medical director to use a specialist that is in the same network as the injured employee's treating doctor in accordance with Insurance Code §1305.104(f) - (i).

(d) Request for an HMO primary care physician or provider as the employee's treating doctor. An injured employee required to

receive health care services within a network may select as the employee's treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care physician or provider under Chapter 843, as the terms "physician" and "provider" are defined in that chapter. The network shall grant an employee's request for an HMO primary care physician or provider to serve as the employee's treating doctor if the physician or provider agrees to abide by the terms of the network's contract and comply with Insurance Code Chapter 1305, Subchapters D - I and commissioner rules adopted under those subchapters, as applicable to treating doctors.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER F. UTILIZATION REVIEW AND RETROSPECTIVE REVIEW

28 TAC §§10.100 - 10.104

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.101. General Standards for Utilization Review and Retrospective Review.

(a) Screening criteria used for utilization review and retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines, return-to-work guidelines, and individual treatment protocols.

(b) The carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.102. Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements.

(a) The preauthorization requirements of Labor Code §413.014 and rules adopted under that section do not apply to health care provided through a workers' compensation network. If a carrier or network uses a preauthorization process within a network, the requirements of Insurance Code §§1305.351 - 1305.355 and this chapter apply.

(b) Any person performing utilization review or retrospective review for an injured employee receiving health care services in a network shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review or retrospective review.

(c) Notification of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria that were used as guidelines in making the determination;

(4) for any provider consulted, the professional specialty;

(5) a description of the procedure for the reconsideration process; and

(6) notification of the availability of independent review in the form prescribed by the commissioner.

(d) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the person performing utilization review must issue and transmit a determination indicating whether the proposed health care services are preauthorized, and respond to requests for preauthorization within the periods prescribed by this section.

(e) If the proposed services are for concurrent hospitalization care, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve post-stabilization treatment or a life-threatening condition, the person performing utilization review must transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the person performing utilization review issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the person performing utilization review must provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under subsection (b) of this section.

(g) For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination under subsection (d) of this section not later than the third calendar day after the date the request is received.

(h) For adverse determinations made pursuant to retrospective review, the adverse determination must be issued in response to a claim for payment consistent with the timelines set forth in Labor Code §408.027 related to payment of health care providers. An adverse determination issued under this subsection must comply with all applicable requirements related to adverse determinations in this section.

(i) Prescribed forms related to the availability of independent review may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§10.103. Reconsideration of Adverse Determination.

(a) A person who performs utilization review or retrospective review shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and include:

(1) a provision stating that a provider other than the provider who made the original adverse determination must perform the reconsideration;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request for reconsideration, the person performing utilization review or retrospective review must send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the person performing utilization review or retrospective review must issue a response letter to the employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) for any provider consulted, the professional specialty and state(s) in which the provider is licensed; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review in the form of notice referenced in §10.102(i) of this subchapter (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements); and

(5) written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the person performing utilization review or retrospective review received the request.

(b) In addition to the requirements in subsection (a) of this section, the reconsideration procedures must include:

(1) a method for expedited reconsideration procedures for:

(A) denials of proposed health care services involving post-stabilization treatment;

(B) life-threatening conditions; and

(C) denials of continued stays for hospitalized employees;

(2) a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review; and

(3) a provision that the period during which the reconsideration is to be completed must be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of receipt of all information necessary to complete the reconsideration.

(c) Notwithstanding subsection (a) or (b) of this section, an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

§10.104. Independent Review of Adverse Determination.

(a) The person who performs utilization review or retrospective review, denies a referral request because the referral is not medically necessary, or denies a request for deviation from treatment guidelines, individual treatment protocols or screening criteria, must:

(1) permit the employee, person acting on behalf of the employee, or the employee's requesting provider to seek review of the referral denial or reconsideration denial within the period prescribed by subsection (b) of this section by an independent review organization assigned in accordance with Insurance Code Article 21.58C and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the person receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents, including treatment guidelines, used by the person in making the determination;

(C) the response letter described by Insurance Code §1305.354(a)(4) and §10.103(a)(4) of this subchapter (relating to Reconsideration of Adverse Determination);

(D) any documentation and written information submitted in support of the request for reconsideration; and

(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

(b) A requestor must timely file a request for independent review under subsection (a) of this section as follows:

(1) for a request regarding preauthorization or concurrent review, not later than the 45th day after the date of denial of a reconsideration; or

(2) for a request regarding retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

(c) The insurance carrier must pay for the independent review provided under this subchapter.

(d) The department shall assign the review request to an independent review organization.

(e) At a minimum, the decision of the independent review organization must include the elements listed and the certification required under Labor Code §413.032.

(f) After an independent review organization's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The division of workers' compensation and the department are not considered to be parties to the medical dispute.

(g) A decision of an independent review organization related to a request for preauthorization or concurrent review is binding. The carrier is liable for health care during the pendency of any appeal, and the carrier and network shall comply with the decision.

(h) If judicial review is not sought under this section, the carrier and network shall comply with the independent review organization's decision.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. COMPLAINTS

28 TAC §§10.120 - 10.122

The new sections are adopted under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §31.001 and §36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5, Subchapter D, relating to workers' compensation insurance, as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A (Health Care Utilization Review Agents). Insurance Code §31.007 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405 (Workers' Compensation Research).

§10.121. Complaints; Deadlines for Response and Resolution.

(a) Not later than seven calendar days after receipt of an oral or written complaint, the network must:

(1) acknowledge receipt of the complaint in writing;

(2) acknowledge the date of receipt; and

(3) provide a description of the network's complaint procedures and deadlines.

(b) A network shall investigate each complaint received in accordance with the network's policies and in compliance with this subchapter.

(c) After a network has investigated a complaint, the network shall issue a resolution letter to the complainant not later than the 30th calendar day after the network receives the written complaint which:

(1) explains the network's resolution of the complaint;

(2) states the specific reasons for the resolution;

(3) states the specialization of any health care provider consulted; and

(4) states that, if the complainant is dissatisfied with the resolution of the complaint or the complaint process, the complainant may file a complaint with the department as described in §10.122 of this subchapter (relating to Submitting Complaints to the Department).

(d) A network shall maintain a complaint log regarding each complaint and categorize each complaint as one or more of the following:

(1) quality of care or services;

(2) accessibility and availability of services or providers;

(3) utilization review and retrospective review, as applicable;

(4) complaint procedures;

(5) health care provider contracts;

(6) bill payment, as applicable;

(7) fee disputes; and

(8) miscellaneous.

(e) Each network must maintain the complaint log required under subsection (d) of this section and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary after the date the complaint was received.

§10.122. Submitting Complaints to the Department.

(a) Any person, including a person who has attempted to resolve a complaint through a network's complaint system process or attempted to resolve a dispute regarding whether the employee lives within the network's service area through the insurance carrier, who is dissatisfied with resolution of the complaint, may submit a complaint to the department.

(b) The department's complaint form may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 1. GENERAL LAND OFFICE

CHAPTER 15. COASTAL AREA PLANNING
SUBCHAPTER A. MANAGEMENT OF THE BEACH/DUNE SYSTEM

31 TAC §§15.24, 15.31. 15.33

The General Land Office (GLO) adopts amendments to §15.24, relating to Certification Status of City of Port Aransas Dune Protection and Beach Access Plan, §15.31, relating to Certification Status of City of Corpus Christi Dune Protection and Beach Access Plan, and §15.33, relating to Certification Status of Nueces County Dune Protection and Beach Access Plan, without changes to the text as published in the September 23, 2005, issue of the *Texas Register* (30 TexReg 6034) and will not be republished.

Pursuant to the Open Beaches Act (Texas Natural Resources Code, Chapter 61), the Dune Protection Act (Texas Natural Resources Code, Chapter 63), and the Beach/Dune Rules (31 TAC §§15.1 - 15.10), a local government with jurisdiction over gulf beaches must submit its beach management plan and amendments to the plan to the GLO for certification, including a plan to impose or increase public beach access, parking, or use fees. The GLO is required to review such plans and certify by rule those plans that are consistent with the Open Beaches Act, the Dune Protection Act, and the Beach/Dune Rules.

The City of Port Aransas, the City of Corpus Christi, and Nueces County, have each requested approval of an increase in the beach user fee imposed in accordance with 31 TAC §15.8 and Texas Natural Resources Code §61.022(c). On March 17, 2005, the City of Port Aransas passed Ordinance No. 2005-03, which amended its dune protection and beach access plan to increase the beach user fee imposed by the City of Port Aransas pursuant to 31 TAC §15.8 from $6.00 per calendar year to $12.00 per calendar year. On April 12, 2005, the City of Corpus Christi passed Ordinance No. 026208, which amended its dune protection and beach access plan to revise the beach user fee plan incorporated as Appendix XVII to provide an increase the beach user fee imposed by the City of Corpus Christi pursuant to 31 TAC §15.8 from $6.00 per calendar year to $12.00 per calendar year. On March 16, 2005, Nueces County adopted Order No. 20050032 which amended the its dune protection and beach access plan to increase the beach user fee imposed by Nueces County pursuant to 31 TAC §15.8 from $6.00 per calendar year to $12.00 per calendar year.

The GLO received one comment from an individual concerning the adopted rulemaking. The commenter questioned whether the amendment to the beach user fee plan in each of the three (3) local governments jurisdictions of Nueces County, City of Corpus Christi and City of Port Aransas would require a user who frequents beaches in all three jurisdictions to purchase a permit in each jurisdiction resulting in a total annual cost of $36.00. The commenter further stated that the fee increase should not be allowed until reciprocal agreements are in place and be part of the proposal to increase fees. The GLO agrees with the commenter that reciprocity agreements should be required as a condition of approval of beach user fee plans. Section 15.8(b) of the Beach/Dune Rules provides that local governments within each county are required to establish a state-approved system for reciprocity of fees and fee privileges among the county and the different local governments authorized to charge beach user fees. As indicated in the notice for the proposed amendments to §§15.24, 15.31, and 15.33, the City of Port Aransas, the City of Corpus Christi, and Nueces County established a unified beach parking permit system in 2002 that allows beach users who purchase a beach parking permit in any one of the three jurisdictions to park on any of the beaches that require a parking permit within the three jurisdictions. The annual cost to a beach user in each of the three jurisdictions would only be $12.00. The revenues received are distributed between the jurisdictions based on the number of linear feet of beach within each jurisdiction.

The GLO reviewed information provided by the City of Port Aransas by letter dated April 26, 2005, in support of its request to amend its beach user fee plan; information provided by the City of Corpus Christi by letter dated October 19, 2004, in support of its request to amend its beach user fee plan; and information provided by Nueces County by letter dated June 10, 2005, in support of its request to amend its beach user fee plan as required by 31 TAC §15.8(d), together with beach user fee revenue reports filed with the GLO by each jurisdiction as required by 31 TAC §15.8(f). Based on the information provided by the City of Port Aransas, the City of Corpus Christi, and Nueces County, the GLO determined that the fee increase requested by each of these jurisdictions is reasonable in that it does not exceed the necessary and actual cost of providing reasonable beach-related facilities and services, does not unfairly limit public use of and access to and from public beaches in any manner, and is consistent with §15.8 of the Beach/Dune Rules and the Open Beaches Act.

The reasoned justification for approval and adoption of the amendments pertaining to beach user fee plans is that the increased fees are necessary for the City of Port Aransas, the City of Corpus Christi, and Nueces County to continue to fund and provide adequate and improved beach-related services to the public including: funding for ensuring safe use of and access to and from the public beach, including vehicular controls, management, and parking regulations; acquisition and maintenance of off-beach parking and access ways; sanitation and litter control, including providing and servicing trash receptacles; lifeguard and lifesaving services; beach maintenance, including removal of debris and relocation of seaweed; law enforcement; beach nourishment projects; beach/dune system education; beach/dune protection and restoration projects; providing public facilities such as portable restrooms, showers, and picnic areas; and permitting of recreational and refreshment vendors. The plans for each jurisdiction also identify no-fee areas as required by 31 TAC §15.8(h), which serve to mitigate the impact of the beach user fee increase.

The GLO adopts amendments to the certification status of the beach access plans for the City of Port Aransas, the City of Corpus Christi, and Nueces County currently summarized in §§15.24, 15.31, and 15.33, respectively, only in regards to approval and certification of beach user fee provisions and does not adopt any other changes to the certification status of the those plans in this rulemaking action.

The adopted amendments to §15.24, relating to Certification Status of City of Port Aransas Dune Protection and Beach Access Plan, §15.31, relating to Certification Status of City of Corpus Christi Dune Protection and Beach Access Plan, and §15.33, relating to Certification Status of Nueces County Dune Protection and Beach Access Plan, are subject to the Coastal Management Program (CMP) as provided in Texas Natural Resources Code §33.2053(a)(10) and 31 TAC §505.11(a)(1)(J), relating to the Actions and Rules Subject to the CMP, and must be consistent with the applicable CMP goals and policies under §501.26, relating to Policies Construction in the Beach/Dune System. The GLO reviewed the adopted rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Council (Council). The adopted action is consistent with the GLO Beach/Dune regulations that the Council has determined to be consistent with the CMP. Consequently, the Land Office has determined that the adopted action is consistent with the applicable CMP goals and policies. No comments on the consistency of the adopted rulemaking were received during the comment period.

The GLO has evaluated the adopted rulemaking action in light of the regulatory analysis requirements of Texas Government Code §2001.0225, and determined that the action is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute. "Major environmental rule" means a rule, the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The adopted amendments are not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the adopted rulemaking implements legislative requirements in Texas Natural Resources Code §§61.011, 61.015(b), and 61.022(c), which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify that plans to impose or increase public beach access, parking, or use fees are consistent with state law.

The amendments are adopted under the Texas Natural Resources Code §§61.011, 61.015(b), and 61.022(c) which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify that plans to impose or increase public beach access, parking, or use fees are consistent with state law.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505374
Trace Finley
Policy Director
General Land Office
Effective date: December 8, 2005
Proposal publication date: September 23, 2005
For further information, please call: (512) 305-8598

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PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 365. INVESTMENT RULES

The Texas Water Development Board (the board) adopts amendments to 31 TAC §365.7 and §365.13 concerning Investment Rules without changes to the proposed text as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6405) and will not be republished. Amendments to these sections are adopted to clarify and expand the scope of the investments of funds in the board portfolio.

The amendments to §365.7(b) are adopted to expand the strategy to invest monies in the Enterprise, Special Revenue, and debt service funds. Currently the board investment strategy lim-

its the investment of these funds to securities backed by the full faith and credit of the U.S. government and U.S. government agencies in a laddered structure or through the use of pooled funds of state agencies in the Texas State Treasury. The amendments would expand the board investment strategy to allow for the investment of these funds, in a laddered structure, to all authorized investments allowed under board rules, as set out in 31 TAC §365.13(a). This broader investment strategy provides for a greater diversity of investments.

The board adds a new §365.13(a)(6) to include commercial paper as an authorized and suitable investment for funds in the board portfolio. The new paragraph authorizes investment in commercial paper which does not exceed 270 days to maturity and which has received the highest short-term credit rating by Fitch, Moody's and Standard & Poor's and all nationally recognized investment rating firms with ratings for such commercial paper. These standards for investing in commercial paper encompass the requirements under the Public Funds Investment Act (Government Code §2256.023) and the board's Clean Water State Revolving Fund Senior Lien Bond Resolution, which governs some of the funds effected by this new paragraph. The new paragraph also excludes the investment of Texas Water Resources Finance Authority funds, managed by the board pursuant to a contractual agreement, in commercial paper. The investment of Texas Water Resources Finance Authority funds is governed by Texas Water Code §20.002(2), which does not permit investment in commercial paper. The addition of commercial paper as an authorized investment provides additional flexibility in the management of the board portfolio with a potential for increased yields. Current §365.13(a)(6) is amended to be §365.13(a)(7).

There were no comments received on the proposed amendments.

SUBCHAPTER A. GENERAL PROVISIONS

31 TAC §365.7

The amendments are adopted under the authority of the Texas Water Code §6.101, which provide the Texas Water Development Board with the authority to adopt rules necessary to carry out the powers and duties in the Texas Water Code and other laws of the State, and the Texas Government Code, Chapters 2256, which requires each State agency to adopt rules regarding the investment of its funds.

There are no statutory provisions affected by the adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505269
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Effective date: December 5, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 475-2052

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SUBCHAPTER B. INVESTMENT PROCEDURES

31 TAC §365.13

The amendments are adopted under the authority of the Texas Water Code §6.101, which provide the Texas Water Development Board with the authority to adopt rules necessary to carry out the powers and duties in the Texas Water Code and other laws of the State, and the Texas Government Code, Chapters 2256, which requires each State agency to adopt rules regarding the investment of its funds.

There are no statutory provisions affected by the adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505270
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Effective date: December 5, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 475-2052

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER C. APPRAISAL DISTRICT ADMINISTRATION

34 TAC §9.415

The Comptroller of Public Accounts adopts an amendment to §9.415, concerning applications for property tax exemptions, without changes to the proposed text as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6406).

Changes to subsection (c) are adopted for clarification purposes and 4 model forms are amended. To clarify the application for the exemption of goods exported from Texas, the comptroller is amending Model Form 50-113. To implement the requirements of law regarding the inclusion of a person's date of birth on the application for residence homestead exemptions, and to clarify instructions, the comptroller is amending Model Form 50-114. To include certain medical facilities on the application for miscellaneous exemptions, the comptroller is amending Model Form 50-128. To implement the requirements of law regarding the deadline for filing an application for a disabled veteran or survivor exemption, the comptroller is amending Model Form 50-135.

The application for exemption of goods exported from Texas (also known as the freeport exemption) is being amended in response to a request from a vendor to clarify the wording of the

third question in step 4 of the form. If inventory is transported for only a portion of the year, it could be eligible for the exemption and space for providing the months during which portions of the inventory were transported is needed. The comptroller is amending Model Form 50-113 to provide additional space for providing this information.

The application for residence homestead exemption is being amended in response to House Bill 2491, 79th Legislature, Regular Session, effective September 1, 2005, requiring that the homestead application form include a space for the applicant to include his or her date of birth. The comptroller is amending Model Form 50-114 to add the space for the date of birth and to provide an explanation that the applicant will be entitled to receive a residence homestead exemption for persons 65 years of age or older without filing another application for that purpose. The model form is being amended to explain that a tax limitation for homeowners who are age 65 or older or disabled is available at the option of counties, cities, or junior college districts and is required for school districts to provide to disabled homeowners. The comptroller is amending Model Form 50-114 to clarify the application instructions concerning tax limitations generally and specifically for surviving spouses of persons age 65 or older or disabled. The model form is also being amended to clarify the description of property in Step 2 concerning the number of acres used for residential occupancy, to amend the instructions concerning applications for the homestead exemption for persons 65 years of age of older, and to correct clerical errors.

The miscellaneous property tax exemption form is being amended to conform to requirements of the law. The comptroller is amending Model Form 50-128 to add medical center developments in populous counties as organizations that may qualify for exemptions from ad valorem taxation and for which annual applications are not required. The amendment also corrects clerical errors on the form.

The application for disabled veteran's or survivor's exemption is being amended in response to Senate Bill 1652, 79th Legislature, Regular Session, effective September 1, 2005. The comptroller is amending Model Form 50-135 to state that an application may be filed no later than one year after the delinquency date for taxes on the property, rather than the first anniversary of the earlier of certain dates.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Tax Code, §11.43(f), which requires the comptroller to prescribe the contents of the application form for each kind of property tax exemption.

The amendment implements Tax Code, §§11.251, 11.43, and 11.439.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 15, 2005.

TRD-200505271

Martin Cherry
Chief Deputy General Counsel
Comptroller of Public Accounts
Effective date: December 5, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 475-0387

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 1. TEXAS DEPARTMENT OF PUBLIC SAFETY

CHAPTER 4. COMMERCIAL VEHICLE REGULATIONS AND ENFORCEMENT PROCEDURES

SUBCHAPTER B. REGULATIONS GOVERNING TRANSPORTATION SAFETY

37 TAC §4.21

The Texas Department of Public Safety adopts new §4.21, concerning Regulations Governing Transportation Safety, with a slight grammatical change to the proposed text as published in the September 30, 2005, issue of the *Texas Register* (30 TexReg 6257). The change in subsection (a) changes "driver's license" to "driver license."

New §4.21 is necessary in order to implement the requirements of Senate Bill 217, 79th Texas Legislature, Regular Session. Senate Bill 217 established reporting requirements for employers for valid positive test results from alcohol and drug tests conducted on holders of commercial driver licenses.

On November 10, 2005, the department held a public hearing to receive comment(s) from all interested person(s) regarding adoption of the new section. No comments were received regarding adoption of the new section.

The new section is adopted pursuant to Texas Transportation Code, §644.051, which authorizes the director to adopt rules regulating the safe transportation of hazardous materials and the safe operation of commercial motor vehicles.

§4.21. Reports of Valid Positive Results on Alcohol and Drug Tests.

(a) Reporting Requirement. An employer required under the federal safety regulations to conduct alcohol and controlled substance testing of employees shall report to the department a valid positive result on an alcohol or controlled substance test performed as part of the carrier's alcohol and drug testing program or consortium, as defined by Title 49, Code of Federal Regulations, Part 382, on an employee of the carrier who holds a commercial driver license issued under Texas Transportation Code, Chapter 522.

(1) The report must be submitted by employers within 10 days of receiving notice of a valid positive result on an alcohol or drug test performed.

(2) The report must be submitted on a form prescribed by the department that is available at the following Internet web site address: http://www.txdps.state.tx.us/forms. All information requested on the form must be completed. The completed form must be mailed to MCCA Section Supervisor, Motor Carrier Bureau, Texas Depart-

ment of Public Safety, 6200 Guadalupe, MSC# 0522, Austin, Texas 78752-4019, or sent by facsimile to (512) 424-5310. Unless the report is for a refusal to submit a sample, employers must also attach a legible copy of either the Federal Drug Testing, Custody and Control Form (with at least steps one through six completed), the U. S. Department of Transportation (DOT) Alcohol Testing Form (with at least steps one through three completed), or the Medical Review Officer's or Breath Alcohol Technician's report of a positive, diluted, adulterated, or substituted alcohol or drug test

(3) When a valid positive result is obtained on an owner-operator, that owner-operator is responsible for submission of the Report of Valid Positive Drug or Alcohol test to the department.

(4) A Medical Review Officer, Breath Alcohol Technician, laboratory, consortium, or other individuals may submit a Report of Valid Positive Drug or Alcohol Test to the department. Reports by laboratories or other individuals will only be entered in the department's database when verified by the Medical Review Officer or Breath Alcohol Technician.

(b) Release of Information. Information regarding Reports of Valid Positive Drug or Alcohol Tests is confidential and only subject to release as provided in Texas Transportation Code, §521.053. A request must be submitted on a form prescribed by the department that is available at the following Internet web site address: http://www.txdps.state.tx.us/forms. The request form must be mailed to MCCA Section Supervisor, Motor Carrier Bureau, Texas Department of Public Safety, 6200 Guadalupe, MSC# 0522, Austin, Texas 78752-4019, or sent by facsimile to (512) 424-5310.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 16, 2005.

TRD-200505315
Thomas A. Davis, Jr.
Director
Texas Department of Public Safety
Effective date: December 6, 2005
Proposal publication date: September 30, 2005
For further information, please call: (512) 424-2135

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CHAPTER 28. DNA, CODIS, FORENSIC ANALYSIS, AND CRIME LABORATORIES
SUBCHAPTER H. ACCREDITATION

37 TAC §28.134

The Texas Department of Public Safety adopts amendments to §28.134, concerning List of Recognized Accrediting Bodies, without changes to the proposed text as published in the October 7, 2005, issue of the *Texas Register* (30 TexReg 6408).

Adoption of amendments to the section is necessary in order to provide for the recognition of additional accrediting bodies specifically for forensic urine drug testing laboratories and for a name change and removal of limitations of scope of accreditation for an existing accrediting body.

No comments were received regarding adoption of the amendments.

The amendments are adopted pursuant to Texas Government Code, §411.0205, which authorizes the director by rule shall establish an accreditation process for crime laboratories, including DNA laboratories, and other entities conducting forensic analyses of physical evidence for use in criminal proceedings.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505364
Thomas A. Davis, Jr.
Director
Texas Department of Public Safety
Effective date: December 8, 2005
Proposal publication date: October 7, 2005
For further information, please call: (512) 424-2135

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 1. MANAGEMENT

The Texas Department of Transportation (department) adopts amendments to §§1.1, 1.2, and 1.5, concerning the Texas Transportation Commission (commission), the Texas Department of Transportation (department), and public hearings. The amendments to §§1.1, 1.2, and 1.5 are adopted without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5751) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

Transportation Code, §201.102, requires the commission to develop and implement policies that clearly separate the policy-making responsibilities of the commission and the management responsibilities of the executive director and staff of the department. Section 1.1 and §1.2 were adopted to implement Transportation Code, §201.102.

Transportation Code, §201.802, requires the commission to develop and implement policies that provide the public with a reasonable opportunity to appear before the commission and speak on any issue under the jurisdiction of the commission. Sections 1.3, 1.4, and 1.5 were adopted to implement §201.802.

Section 1.1(b) lists the duties of the commission. The section is amended to add the regulation of the distribution and sale of motor vehicles and for the protection of consumers who purchase new motor vehicles. House Bill 2702, 79th Legislature, Regular Session, 2005, abolished the Motor Vehicle Board and transferred its rulemaking powers to the commission. Section 1.1(b) is also amended to delete the provision concerning commission authorization to charge a toll for the use of one or more lanes on a segment of the state highway system for the purpose of congestion mitigation. The statute granting this power was re-codified and consolidated with the commission's other toll powers so that this item no longer merits a separate listing.

Section 1.2(e) describes the duties of the Motor Vehicle Board. This subsection is deleted due to the provisions of House Bill 2702 that abolish the Motor Vehicle Board.

Section 1.5(a) lists the subjects of public hearings to be held by the commission or its designee. The item describing public input regarding the design and environmental impact of transportation projects is revised to correct a cross-reference to the department's environmental review and public involvement rules. The item concerning converting a non-tolled highway to a toll project is revised to reflect re-codification of the department's toll statutes. The item concerning transferring a state highway to various entities is deleted due to statutory changes made by House Bill 2702.

COMMENTS

No comments on the proposed amendments were received.

SUBCHAPTER A. ORGANIZATION AND RESPONSIBILITIES

43 TAC §1.1, §1.2

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.102 and §201.802

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505343
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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SUBCHAPTER B. PUBLIC MEETINGS AND HEARINGS

43 TAC §1.5

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Transportation Code, §201.102 and §201.802

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505344
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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SUBCHAPTER F. ADVISORY COMMITTEES

43 TAC §§1.82, 1.84, 1.85

The Texas Department of Transportation (department) adopts amendments to §§1.82, 1.84, and 1.85, concerning advisory committees. The amendments to §§1.82, 1.84, and 1.85 are adopted without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5753) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The department adopts amendments to its rules governing advisory committees to reflect recently enacted legislation, extend committee sunset dates, and to make minor revisions.

Section 1.82 prescribes rules governing the operations and procedures of department advisory committees that are created specifically by state law.

Section 1.82(c) currently requires the filing of an open meeting notice to be coordinated through the department's general counsel. To acknowledge that individuals other than the general counsel may review, approve, and file a notice, §1.82(c) is amended to require notice to be coordinated through the department's Office of General Counsel.

Section 1.82(d) currently provides that advisory committee members are not entitled to receive compensation for serving as members. This rule was originally adopted due to the lack of authority under the general appropriations act to reimburse committee members for their necessary expenses. The current appropriations act does allow reimbursement if approved by the governor and the Legislative Budget Board. To allow for a circumstance where the department may wish to seek approval to reimburse committee members, §1.82(d) is amended to provide that the department may, if authorized by law and the department's executive director, reimburse a committee member for reasonable and necessary travel expenses.

Section 1.82(i) currently provides that each statutory advisory committee is abolished December 31, 2005. This sunset date was established to comply with Government Code, §2110.008, which requires a state agency to establish by rule a date on which advisory committees will automatically be abolished unless continued. The commission determines that its statutory advisory committees are necessary to improve communication between the department and the public. Therefore, §1.82(i) is amended to revise the sunset date to December 31, 2007.

Section 1.84 creates the department's statutory advisory committees and describes the committees' purpose and duties.

Section 1.84(d) creates the Border Trade Advisory Committee. To comply with Senate Bill 183, 79th Legislature, Regular Ses-

sion, 2005, §1.84(d) is amended to: (1) include the governor as a party to the exchange of communications facilitated by the committee; (2) state that the membership of the committee shall be as provided by Government Code, §772.010; (3) authorize the commission to alter the terms of some members to provide for staggered terms; and (4) provide that the committee may not be abolished as provided by §1.82.

Section 1.85 provides for the creation and operating procedures of advisory committees that are not created by statute.

Section 1.85(a)(1) authorizes the creation of project advisory committees for the purpose of facilitating, evaluating, and achieving support and consensus from the affected community and governmental entities in the initial stages of a highway improvement project. Recognizing that the legislature continues to expand the department's authority to develop aviation, rail, and transit projects, §1.85(a)(1) is amended to allow the creation of this type of committee for a "transportation" project, instead of just "highway improvement" project.

Section 1.85(a)(4) provides for the creation of a Bicycle Advisory Committee. To comply with Senate Bill 602, 79th Legislature, Regular Session, 2005, §1.85(a)(4) is amended to add a new duty for the committee: advise and make recommendations to the commission on the development of bicycle tourism trails. To codify current department practice, §1.85(a)(4) is also amended to add another new duty for the committee: provide recommendations on the selection of projects concerning the Safe Routes to School Program. To be consistent with new §1.85(d), the authority to reimburse members of the committee for their travel expenses is deleted.

Section 1.85(c) currently provides that each advisory committee created under §1.85 is abolished December 31, 2005. This sunset date was established to comply with Government Code, §2110.008. The commission determines that each committee created under §1.85 is necessary to improve communication between the department and the public. Therefore, §1.85(c) is amended to revise the sunset date to December 31, 2007.

Section 1.85(d) is added to allow the department, if authorized by law and the department's executive director, to reimburse advisory committee members for reasonable and necessary travel expenses.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.114, which requires the commission to establish a Border Trade Advisory Committee; Transportation Code, §21.003, which establishes an Aviation Advisory Committee; Transportation Code, §455.004, which establishes a Public Transportation Advisory Committee; and Government Code, Chapter 2110, which governs the operations of state agency advisory committees.

CROSS REFERENCE TO STATUTE

Government Code, Chapter 2110, Transportation Code, §21.003, Transportation Code, §201.101, Transportation Code, §201.114, and Transportation Code §455.004

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505345
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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CHAPTER 9. CONTRACT MANAGEMENT
SUBCHAPTER A. GENERAL

43 TAC §9.1

The Texas Department of Transportation (department) adopts amendments to §9.1, concerning claims for purchase contracts. The amendments to §9.1 are adopted without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5755) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

House Bill 1940, 79th Legislature, Regular Session, 2005, amended Government Code, Chapter 2260. That chapter contains the procedure for resolving contract claims that arise under the State Purchasing and General Services Act, Government Code, Chapter 2155. The Texas Transportation Commission (commission) has previously adopted §9.1 to implement that procedure.

The adopted amendments make three changes to the current rule. First, §9.1(b)(3) is amended to update the definition of director of contract services to reflect the incorporation of the former Contract Services Office into the Office of General Counsel. Second, §9.1(d)(1) is amended to provide that negotiations will start no later than 120 days after a claim is received. This change makes the rule consistent with the statutory change made by House Bill 1940. And third, the reference to §1.21 is changed to update the subchapter title.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, under Government Code, §2260.052(c), which requires each state agency with rulemaking authority to adopt rules governing the negotiation of claims under Government Code, Chapter 2260.

CROSS REFERENCE TO STATUTE

Government Code, Chapter 2260

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505346
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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SUBCHAPTER B. HIGHWAY IMPROVEMENT CONTRACTS

43 TAC §§9.15, 9.17, 9.18

The Texas Department of Transportation (department) adopts amendments to §§9.15, 9.17, and 9.18, concerning highway improvement contracts. The amendments to §§9.15, 9.17, and 9.18 are adopted without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5756) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

Transportation Code, Chapter 223, Subchapter A, prescribes the method by which the department receives competitive bids for the improvement of highways that are a part of the state highway system. Pursuant to this authority, the Texas Transportation Commission (commission) has previously adopted §§9.10 - 9.21 to specify the process by which the department will administer and manage highway improvement contracts.

Section 9.15(b)(1)(H) is revised to state that a proposal will not be accepted or read if, when required, the bid does not include a fully completed historically underutilized business subcontracting plan as prescribed by §9.54(c)(1) of this title (relating to Historically Underutilized Business (HUB) Program). This revision is necessary to provide clarity regarding specific HUB plan requirements associated with bid acceptance or rejection by the department.

Section 9.17(d) is revised to increase the maximum bid amount from $100,000 to $300,000 for the possible award of a maintenance contract to the second lowest bidder when the lowest bidder withdraws their bid after bid opening. This revision is necessary in order to implement statutory revisions to Transportation Code, §223.0041, as contained in Senate Bill 573, 79th Legislature, Regular Session, 2005.

Section 9.18(c) is revised to allow for an alternative form of performance and payment bond on maintenance contracts. This revision is necessary in order to implement statutory revisions to Transportation Code, §223.042, as contained in House Bill 2659, 79th Legislature, Regular Session, 2005.

Revisions to §§9.15, 9.17 and 9.18 also include minor formatting changes. To be consistent, references to "this title" have been changed to "this chapter."

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §§223.001 - 223.016, which requires the department to competitively bid highway improvement contracts.

CROSS REFERENCE TO STATUTE

Transportation Code, §223.0041 and §223.042

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505347
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: December 8, 2005
Proposal publication date: September 9, 2005
For further information, please call: (512) 463-8630

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SUBCHAPTER G. CONTRACTOR SANCTIONS

43 TAC §9.106

The Texas Department of Transportation (department) adopts amendments to §9.106, concerning contractor sanctions. The amendments to §9.106 are adopted without changes to the proposed text as published in the September 9, 2005, issue of the *Texas Register* (30 TexReg 5757) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The Texas Department of Transportation's contractor sanction rules set forth the circumstances under which contractors may be sanctioned and the procedures that must be followed. The Texas Transportation Commission (commission) has previously adopted §§9.100 - 9.106 to specify the process by which the department will administer and manage highway improvement contracts.

Section 9.106(a)(5) and (6) are combined to provide that sanctions may be imposed if a contractor fails to execute a highway improvement contract after a bid is awarded and fails to honor a bid guaranty submitted under §9.14(d) of this chapter (relating to Submittal of Proposal). A contractor will no longer be sanctioned for failure to execute a contract if the bid guaranty is honored, because collection of the bid guaranty is sufficient. This revision is necessary to protect the integrity of the department's competitive bidding process and clarify the specific instances when sanctions would apply in the event an awarded highway improvement is not executed.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

None

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 18, 2005.

TRD-200505348

Richard D. Monroe
General Counsel
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REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Agency Rule Review Plan

Texas Board of Veterinary Medical Examiners

Title 22, Part 24

TRD-200505467
Filed: November 23, 2005

♦ ♦ ♦

Proposed Rule Reviews

Texas State Board of Pharmacy

Title 22, Part 15

The Texas State Board of Pharmacy files this notice of intent to review Chapter 291, Subchapter C (§§291.51 - 291.55), concerning Nuclear Pharmacy (Class B), pursuant to the Texas Government Code §2001.039, regarding Agency Review of Existing Rules.

Comments regarding whether the reason for adopting the rule continues to exist, may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas, 78701, FAX (512) 305-8082. Comments must be received by 5 p.m., January 20, 2006.

TRD-200505433
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: November 22, 2005

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The Texas State Board of Pharmacy files this notice of intent to review Chapter 305, (§305.1 and §305.2), concerning Educational Requirements, pursuant to the Texas Government Code §2001.039, regarding Agency Review of Existing Rules.

Comments regarding whether the reason for adopting the rule continues to exist, may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas, 78701, FAX (512) 305-8082. Comments must be received by 5 p.m., January 20, 2006.

TRD-200505434
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: November 22, 2005

♦ ♦ ♦

The Texas State Board of Pharmacy files this notice of intent to review Chapter 309, (§§309.1 - 309.8), concerning Generic Substitution, pursuant to the Texas Government Code §2001.039, regarding Agency Review of Existing Rules.

Comments regarding whether the reason for adopting the rule continues to exist, may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas, 78701, FAX (512) 305-8082. Comments must be received by 5 p.m., January 20, 2006.

TRD-200505435
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: November 22, 2005

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Texas Board of Veterinary Medical Examiners

Title 22, Part 24

The Texas Board of Veterinary Medical Examiners ("the Board") files this notice of intention to review and consider for readoption, amendment, or repeal Chapter 571, Licensing, Chapter 573, Rules of Professional Conduct, Chapter 575, Practice and Procedure, and Chapter 577, General Administrative Duties, Title 22, Part 24, of the Texas Administrative Code. This review is being conducted in accordance with §2001.039 of the Texas Government Code, which requires the Board and other governmental bodies to review their rules every four years. The review will include an assessment as to whether the reasons for adopting or readopting the rules in Chapters 571, 573, 575, and 577 continue to exist. With this proposed rule review, the Board has also contemporaneously filed a rule review plan, which will be made available on the Secretary of State's Web site at www.sos.state.tx.us. Written comments pertaining to this proposed rule review must be submitted to Lee H. Mathews, General Counsel, 333 Guadalupe, Tower 3, Suite 810, Austin, Texas, 78701, (512) 305-7561, lee.mathews@tbvme.state.tx.us. The deadline for written comments is 30 days after publication in the *Texas Register*. Any changes to these rules proposed because of the rule review will be published in the Proposed Rule section of the *Texas Register*. The proposed rule changes will be open for public comment before final adoption or repeal in accordance with the requirements of the Administrative Procedure Act, Chapter 2001, of the Texas Government Code.

TRD-200505470

Julie A. Barker
Executive Assistant
Texas Board of Veterinary Medical Examiners
Filed: November 23, 2005

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Adopted Rule Review

Texas Water Development Board

Title 31, Part 10

Pursuant to the notice of intent to review published in the September 2, 2005 issue of the *Texas Register*, (30 TexReg 5389), the Texas Water Development Board (the board) has reviewed and considered for readopting, revision or repeal 31 TAC, Part X, Chapter 356, Groundwater Management, in accordance with the Government Code, §2001.039.

The board considered, among other things, whether the reasons for adoption of these rules continue to exist. No comments were received on the proposed rule review.

As a result of the review, the board determined that the rules are still necessary and readopts the sections because they govern the board's procedures for reviewing and approving management plans as administratively complete. As a result of the review, the board renames Subchapter A to Groundwater Management Plan Approval; and concurrently adopts amendments to §356.1 through §356.10 and new §356.11 through §356.13. This completes the board's review of 31 TAC Chapter 356.

TRD-200505469
Jonathan Steinberg
Deputy Counsel
Texas Water Development Board
Filed: November 23, 2005

♦ ♦ ♦

TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure 1: 16 TAC §65.100(h)(1)

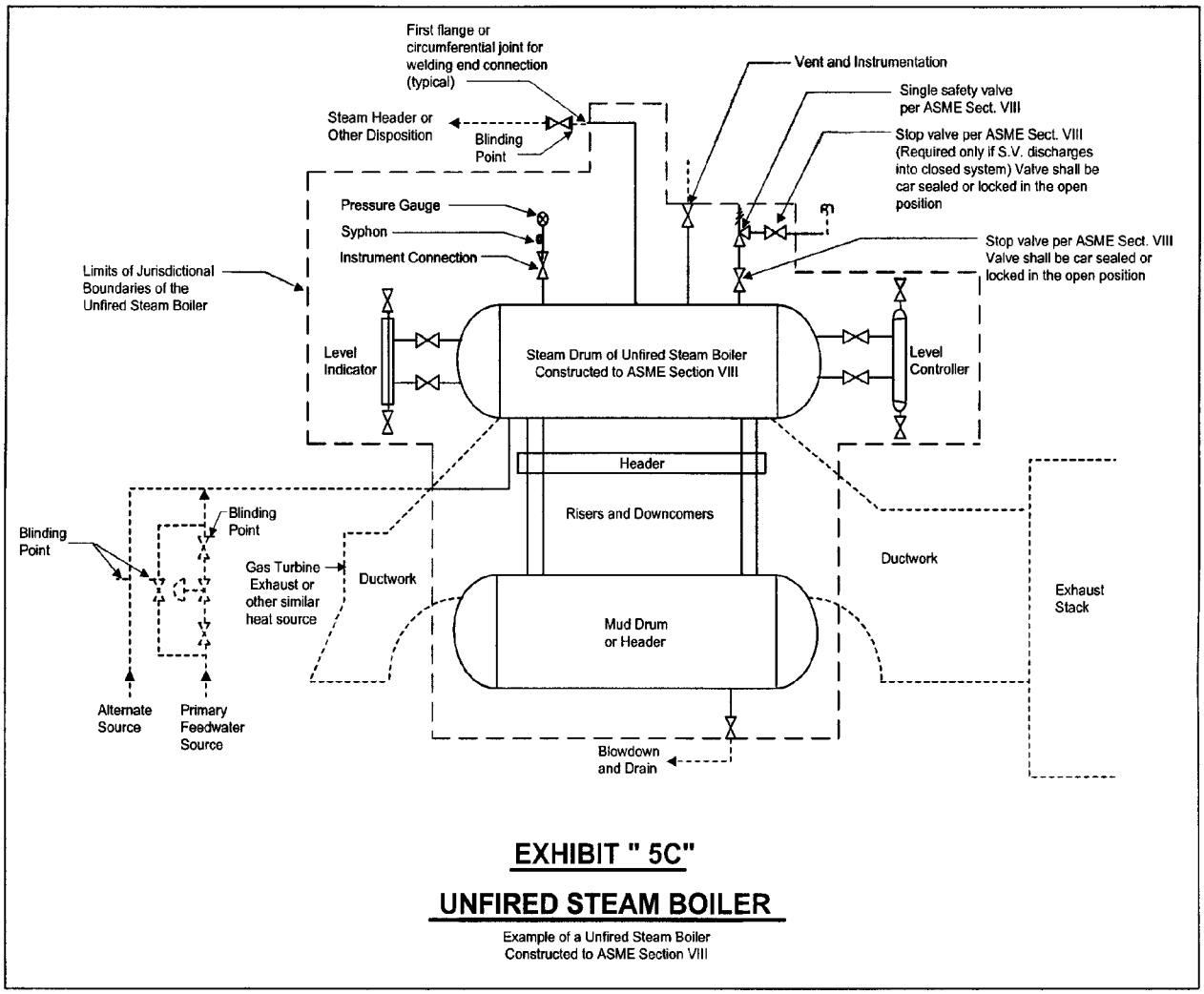


Figure 2: 16 TAC §65.100(h)(1)

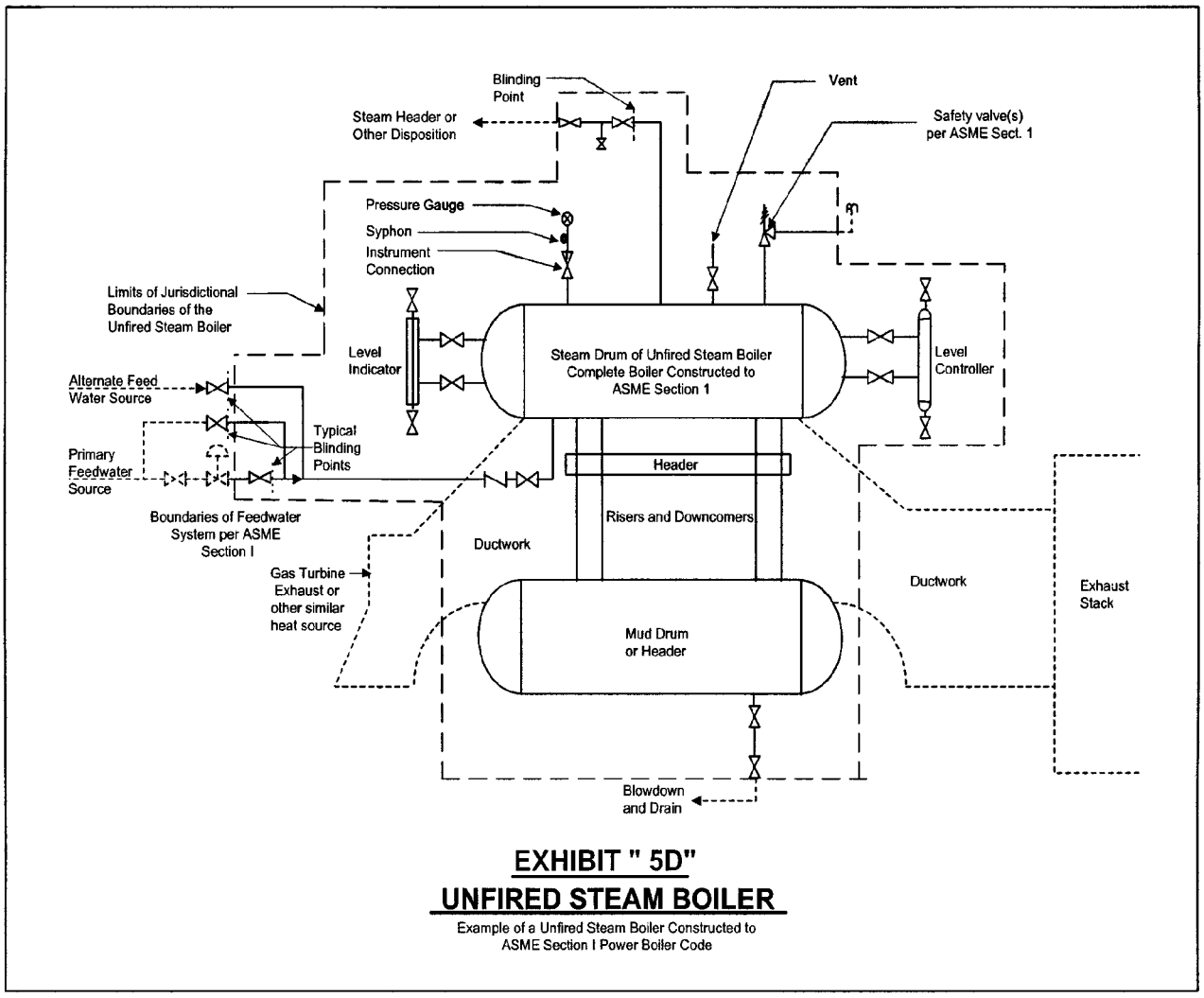


Figure 1: 16 TAC §65.100(i)(1)

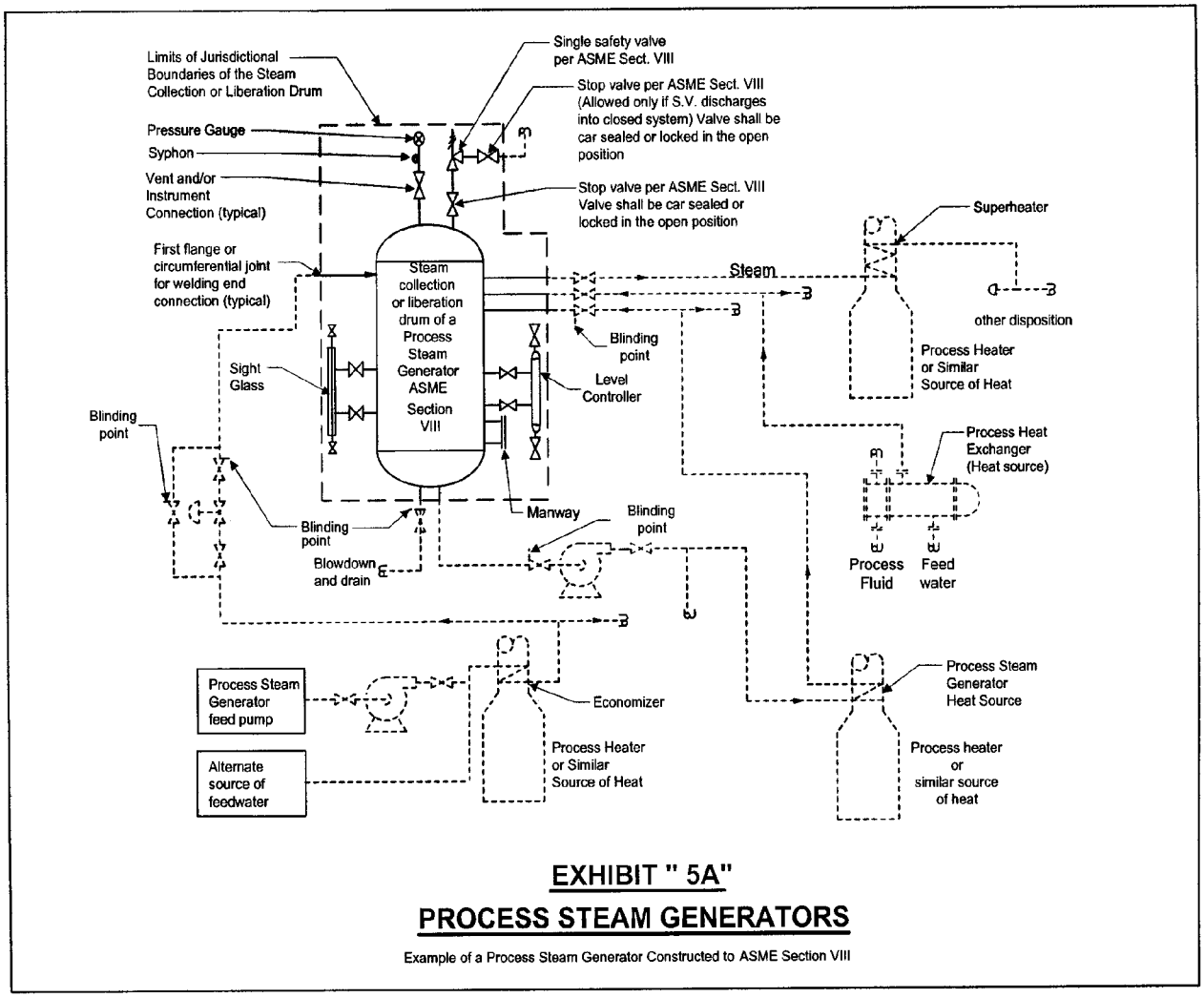


Figure 2: 16 TAC §65.100(i)(1)

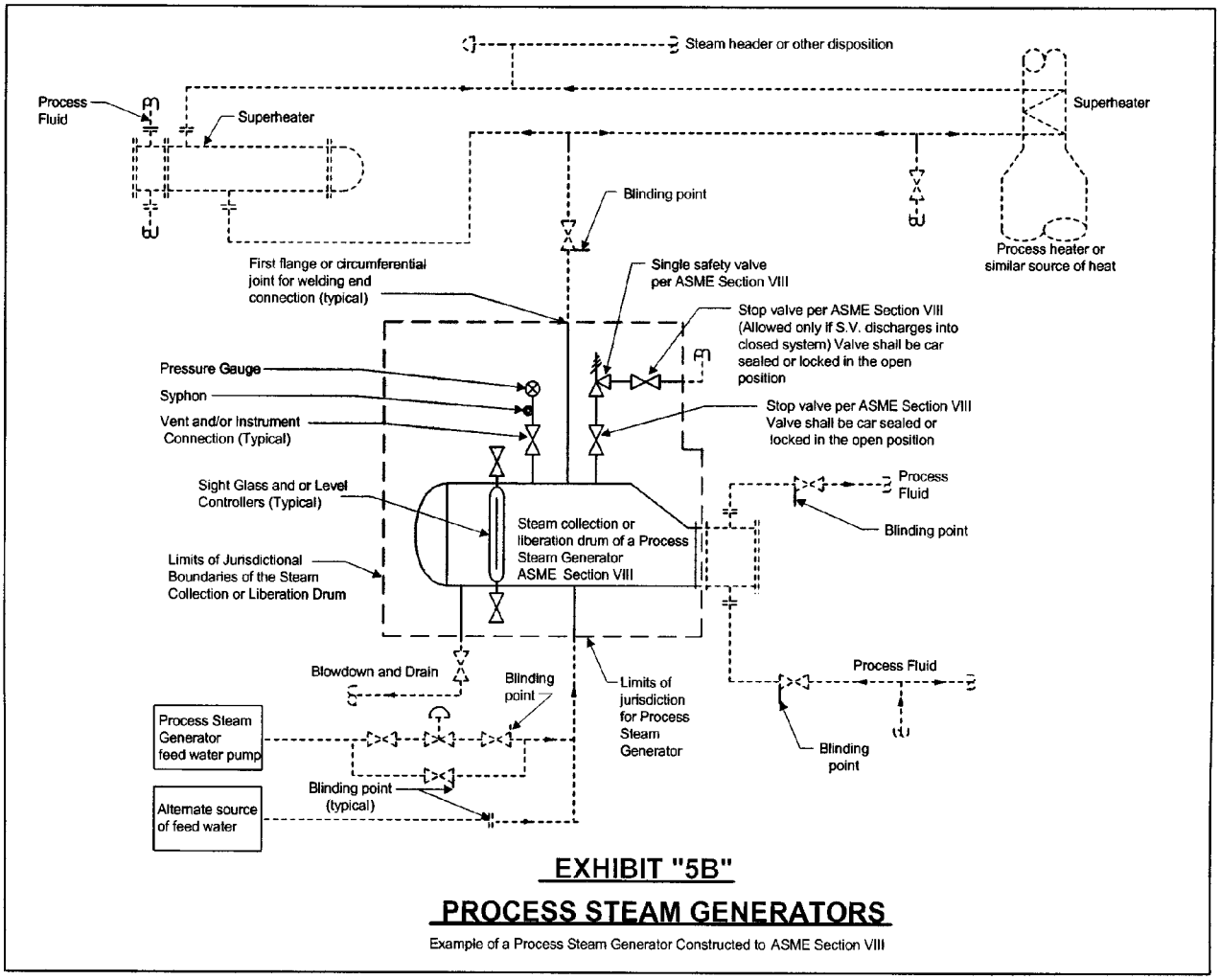


Figure: 16 TAC §65.100(j)(6)

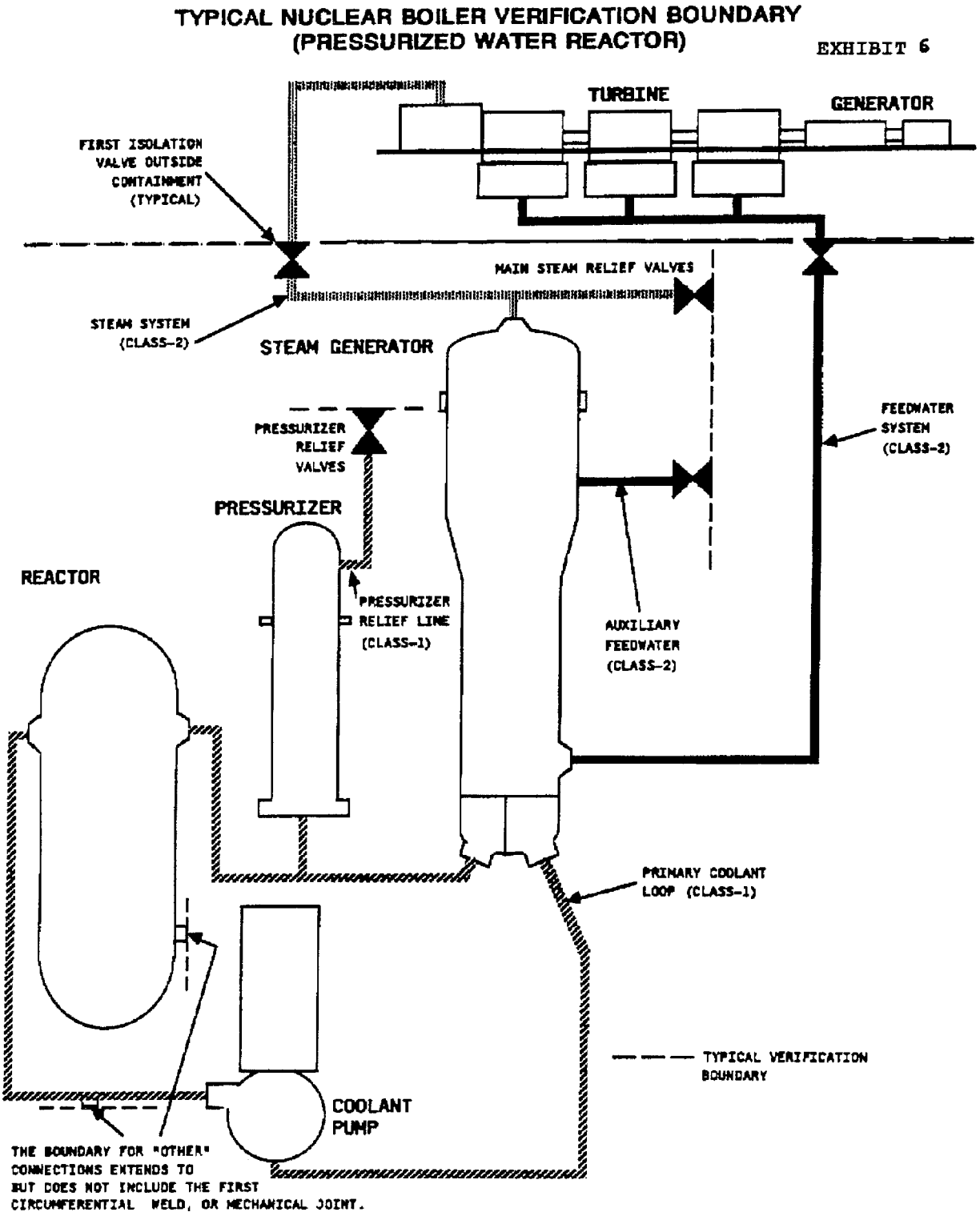


Figure: 16 TAC §65.100(k)(1)(A)(v)

TABLE 1

MINIMUM POUNDS OF STEAM PER HOUR
PER SQUARE FOOT (METER) OF HEATING SURFACE

	Firetube Boilers	Watertube Boilers
Boiler Heating Surface		
Hand fired	5 (24)	6 (29)
Stoker fired	7 (34)	8 (39)
Oil, gas or pulverized fuel fired	8 (39)	10 (49)
Waterwall Heating Surface		
Hand fired	8 (39)	8 (39)
Stoker fired	10 (49)	12 (59)
Oil, gas, or pulverized fuel fired	14 (68)	16 (78)

Note: The minimum safety valve or safety relief valve relieving capacity for electric boilers shall be 3 ½ lb/hr/kw (1.6 kg/hr/kw) input.

TABLE 2

SIZE OF BOTTOM BLOWOFF PIPING, VALVES, AND COCKS

Minimum Required Safety Valve Capacity lb. (kg) of Steam/Hr.	Blowoff Piping Valves, and Cocks Size, min. in. (mm)
(Note)	
Up to 500 (226)	¾ (20)
501 to 1,250 (227 to 567)	1 (25)
1,251 to 2,500 (568 to 1184)	1 ¼ (32)
2,501 to 6,000 (1185 to 2721)	1 ½ (40)
6,001 (2722) and Larger	2 (50)

Note: To determine the discharge capacity of safety relief valves in terms of Btu, the relieving capacity in lbs. of steam/hr. is multiplied by 1,000.

Figure: 16 TAC §82.101(e)

Curriculum to Prepare a Student for the Examination for the Teacher's Certificate 1,000 hours			
(1)	orientation, consisting of		8 hours
	(A)	rules and regulations of the school	
	(B)	introductions to school personnel and students	
	(C)	layout of school facilities	
(2)	instruction in theory, consisting of		125 hours
	(A)	lesson planning	15
	(B)	personality and professional conduct	15
	(C)	development of a barber course	15
	(D)	student learning principles	10
	(E)	principles of teaching	10
	(F)	basic teaching methods	10
	(G)	teaching aids	10
	(H)	testing	10
	(I)	self evaluation	10
	(J)	teaching adults	10
	(K)	classroom problems	5
	(L)	classroom management	5
(3)	instruction in practical work, consisting of		867 hours
	(A)	assisting with senior students	346
	(B)	assisting with junior students	321
	(C)	theory class (assisting teacher, observing, teaching)	125
	(D)	learning office procedures and state laws	50
	(E)	grading test papers (assisting teacher, observing, grading)	25

Figure: 16 TAC §82.101(f)

Curriculum to Prepare a Student for the Examination for the Class A Barber Certificate 1,500 hours				
(1)	orientation, consisting of			8 hours
	(A)	rules and regulations of the school		
	(B)	introduction to school personnel and students		
	(C)	outlay of school facilities conducted		
(2)	theory, consisting of			180 hours
	(A)	anatomy, physiology, and histology, consisting of the study of		50 hours
		(i)	Hair	
		(ii)	Skin	
		(iii)	Muscles	
		(iv)	Nerves	
		(v)	Cells	
		(vi)	circulatory system	
		(vii)	Digestion	
		(viii)	Bones	
	(B)	Texas Barber Law		35
	(C)	bacteriology, sterilization, and sanitation		30
	(D)	disorders of the skin, scalp, and hair		10
	(E)	Salesmanship		5
	(F)	barbershop management		5
	(G)	chemistry		5
	(H)	Shaving		5
	(I)	scalp, hair treatments and skin		5
	(J)	Sanitary professional techniques		4
	(K)	professional ethics		4
	(L)	Scientific fundamentals of barbering		4
	(M)	cosmetic preparations		3
	(N)	shampooing and rinsing		2
	(O)	cutting and processing curly and over-curly hair		2
	(P)	haircutting, male and female		2
	(Q)	theory of massage of scalp, face and neck		2
	(R)	hygiene and good grooming		1
	(S)	barber implements		1
	(T)	honing and stropping		1
	(U)	mustaches and beards		1

	(V)	facial treatments		1
	(W)	electricity and light therapy		1
	(X)	history of barbering		1
(3)	instruction in practical work, consisting of the study of:			1312 hours
	(A)	dressing the hair, consisting of:		800
		(i)	men's haircutting	
		(ii)	children's haircutting	
		(iii)	women's haircutting	
		(iv)	cutting and processing curly and over-curly hair	
		(v)	razor cutting	
	(B)	Shaving		80
	(C)	Styling		55
	(D)	shampooing and rinsing		40
	(E)	bleaching and dyeing of the hair		30
	(F)	waving hair		28
	(G)	Straightening		25
	(H)	Cleansing		25
	(I)	professional ethics		22
	(J)	barbershop management		22
	(K)	hair weaving and hairpieces		17
	(L)	Processing		15
	(M)	Clipping		15
	(N)	beards and mustaches		15
	(O)	Shaping		15
	(P)	Dressing		15
	(Q)	Curling		15
	(R)	first aid and safety precautions		11
	(S)	scientific fundamentals of barbering		10
	(T)	barber implements		10
	(U)	haircutting or the process of cutting, tapering, trimming, processing, and molding and scalp, hair treatments, and tonics		10
	(V)	message and facial treatments		10
	(W)	Arranging		10
	(X)	Beautifying		10
	(Y)	Singeing		7
	(Z)	Manicuring		Optional

Figure: 16 TAC §82.101(g)

Curriculum to Prepare a Student for the Examination for the Manicurist License 600 hours--minimum of 16 weeks			
(1)	orientation, consisting of		8 hours
	(A)	rules and regulations of the school	
	(B)	introduction to school personnel and students	
	(C)	layout of school facilities	
(2)		instruction in theory, consisting of	37 hours
	(A)	bacteriology, sterilization, and sanitation	8
	(B)	manicuring, equipment, and procedures	4
	(C)	the nail and disorders	4
	(D)	Texas barber laws	4
	(E)	anatomy and physiology	4
	(F)	skin	4
	(G)	professional ethics	3
	(H)	hygiene and good grooming	3
	(I)	advanced nail techniques	3
(3)	instruction in practical work, consisting of:		555 hours
	(A)	shaping nails	96
	(B)	applying polish	74
	(C)	trimming cuticle and buffing nails	59
	(D)	hand and arm massage	57
	(E)	removal of polish	57
	(F)	application of artificial and gel nails	44
	(G)	applying cuticle remover and loosening	40
	(H)	preparation of manicure table	40
	(I)	softening cuticle	37
	(J)	bleaching under free edge	18
	(K)	cleaning under free edge	18
	(L)	applying cuticle oil or cream	15

Figure: 16 TAC §82.101(h)

Curriculum to Prepare a Student for the Examination for the Barber Technician License 300 hours			
(1)	orientation, consisting of		8 hours
	(A)	rules and regulations of the school	
	(B)	introduction to school personnel and students	
	(C)	layout of school facilities	
(2)	instruction in theory, consisting of		37 hours
	(A)	hygiene, bacteriology, sterilization, and sanitation	10
	(B)	common disorders of the skin; facial treatments	4
	(C)	shampooing, equipment, and procedures	4
	(D)	Texas barber laws	4
	(E)	cosmetic applications and massage	3
	(F)	professional ethics	3
	(G)	good grooming; preparing patron and making appointments	3
	(H)	theory of massage, and structure of head, neck, and face	2
	(I)	rinsing, types and procedures	2
	(J)	scalp and hair treatments	2
(3)	instruction in practical work, consisting of		255 hours
	(A)	application of shampoo and shampooing	45
	(B)	application of rinses and removal	35
	(C)	makeup application	33
	(D)	facial manipulations	20
	(E)	application of conditioner and rinsing	20
	(F)	scalp manipulations	20
	(G)	brushing and drying	18
	(H)	sanitation and sterilization	15
	(I)	draping and scalp examination	11
	(J)	application and removal of creams	10
	(K)	application and removal of packs	8
	(L)	set-up for facial	8
	(M)	preparation of work area for shampooing	7
	(N)	patron protection	5

Figure: 16 TAC §82.101(i)

Curriculum for a Barber Refresher Course 300 hours			
(1)	theory instruction in Texas barber laws		10 hours
(2)	instruction in practical work, to include		290 hours
	(A)	Haircutting	160
	(B)	permanent waving and chemical application	75
	(C)	styling, curling, and blow-drying	55

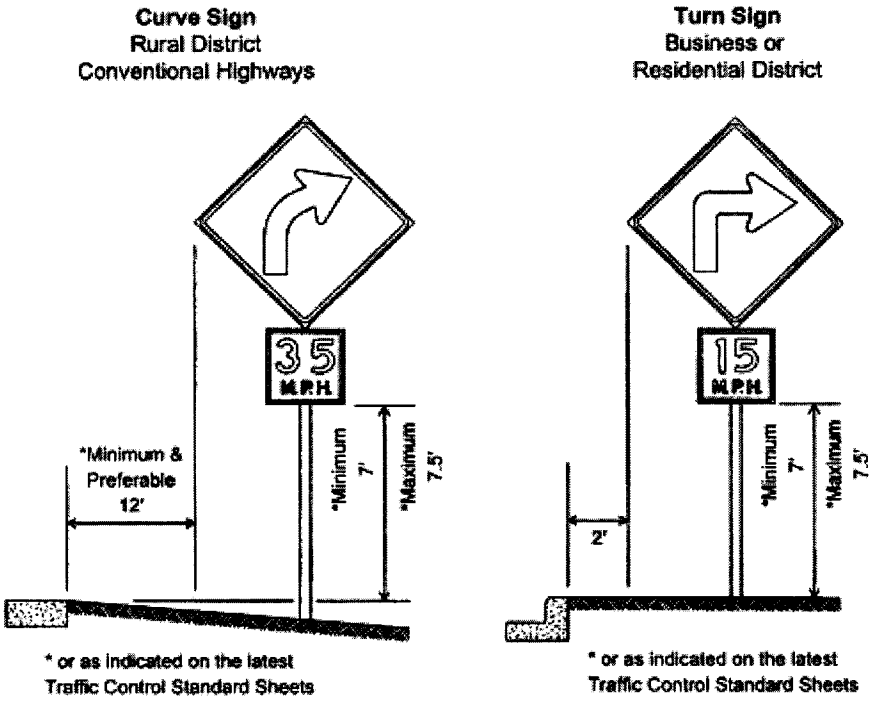
Figure: 37 TAC §439.19(b)

Recommended Hours	No. Questions	Maximum No. Pilot Questions	Time Allowed
30 or less	25	5	30 minutes
31 - 100	50	5	1 hour
101 - 200	75	10	1.5 hours
201 - 300	100	15	2 hours
301 - 400	125	20	2.5 hours
401 or more	150	25	3 hours

Figure: 43 TAC §18.16(a)

Type of Vehicle	Minimum Insurance Level
1. Tow trucks and household goods carriers (gross vehicle weight less than 26,000 lbs.).	$300,000
2. Buses designed or used to transport more than 15 passengers (including the driver), but fewer than 26 passengers (not including the driver).	$500,000
3. Commercial motor vehicles which are buses with a seating capacity of 15 passengers or fewer (including the driver) operated by a foreign motor carrier and foreign motor private carrier as defined in 49 USC §13102.	$1,500,000
4. Buses designed or used to transport 26 passengers or more (not including the driver).	$5,000,000
5. Commercial school buses, regardless of the passenger capacity as described in Transportation Code, §643.1015.	$500,000
6. Commercial motor vehicles that are buses with a seating capacity of 16 passengers or more (including the driver) operated by a foreign motor carrier or foreign motor private carrier as defined in 49 USC §13102.	$5,000,000
7. Farm trucks (gross vehicle weight 48,000 lbs. or more).	$500,000
8. Commercial motor vehicles (gross vehicle weight in excess of 26,000 lbs.), including tow trucks.	$500,000
9. Commercial motor vehicles, as defined in 49 CFR §390.5, operated by a foreign motor carrier or foreign motor private carrier as defined in 49 USC §13102.	$750,000
10. Commercial motor vehicles--Oil listed in 49 CFR §172.101; hazardous waste, hazardous materials and hazardous substances defined in 49 CFR §171.8 and listed in 49 CFR §172.101, but not mentioned in item 10 of this table.	$1,000,000
11. Commercial motor vehicles--Hazardous substances, as defined in 49 CFR §171.8, transported in cargo tanks, portable tanks, or hopper-type vehicles with capacities in excess of 3,500 water gallons; or any quantity of Division 1.1, 1.2, and 1.3 materials, any quantity of Division 2.3, Hazard Zone A material; in bulk Division 2.1 or 2.2; or highway route controlled quantities of a Class 7 material, as defined in 49 CFR §173.403.	$5,000,000

Figure: 43 TAC §25.25(a)(2)(C)



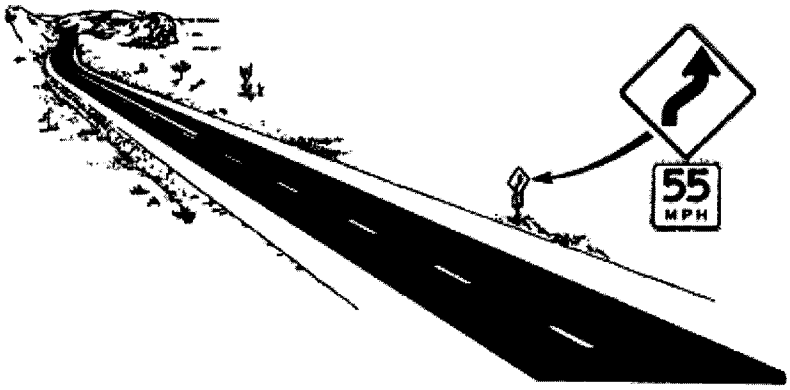


Figure 1: Typical height and location of warning and advisory speed signs.

Figure: 43 TAC §25.25(b)(2)(B)

$$V = \sqrt{15R(e+f)}$$

where:

V = vehicle speed in miles per hour (mph)

R = radius of curve in feet

e = rate of roadway superelevation in feet per foot

f = side friction factor with value depending on speed as follows:

If the speed is:	**Then the side friction factor is:**
35 mph or greater	0.15
between 20 and 35 mph	0.18
20 mph or less	0.31

Figure: 43 TAC §25.25(e)(3)

$$d = \frac{V^2}{30(0.4 \pm g)} + 2.93V$$

where:

d = sight distance for safe stopping distance in feet

V = the velocity in miles per hour

g = percent of grade (in decimal form) divided by 100

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas State Affordable Housing Corporation

Notice of Request for Proposals

Notice is hereby given of Requests for Proposals (RFPs) by the Texas State Affordable Housing Corporation (TSAHC) to multifamily developers for the development of affordable multifamily housing in Texas financed by private activity bonds (to be issued by TSAHC) and low income housing tax credits (to be issued by the Texas Department of Housing and Community Affairs). The Corporation has set forth specific criteria for the development of multifamily housing in three areas: rehabilitation, senior, and rural housing. Each RFP can be viewed on TSAHC's web site (www.tsahc.org) in the Multifamily Bond Programs section. Proposals under all three RFPs will be due at the TSAHC offices in Austin by 2:00 p.m. on the date specified in each RFP. For rehabilitation and senior proposals, the due date is Friday, January 20, 2006; and for rural housing proposals, the due date is Friday, March 10, 2006. Any questions about the Requests for Proposals must be e-mailed or faxed to Cari Garcia at cgarcia@tsahc.org or (512) 477-3557. All questions and responses will be posted on TSAHC's web site.

TRD-200505395
David Long
President
Texas State Affordable Housing Corporation
Filed: November 21, 2005

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Texas Department of Agriculture

Request for Proposals: Texas Yes! Matching Funds Program

Department of Agriculture (the department) hereby requests proposals for Texas Yes! Matching Fund Program projects for the period of September 1, 2005, through August 31, 2007. The Texas Yes! Hometown STARS Matching Fund Program is a matching funds reimbursement program designed to directly promote tourism in rural Texas by developing promotional campaigns based on project requests submitted by successful applicants. Program and project proposal application information can be obtained at: www.texasyes.org or by contacting the Funding Coordinator at (512) 463-7731 or (866) 4TEX-YES. This Request for Proposals (RFP) supersedes the RFP published by the department in the July 29, 2005, issue of the *Texas Register* (30 TexReg 4341).

Eligibility. To be eligible for participation in the matching funds program, an applicant must be a Texas Yes! community member who is a city or county, and is in good standing with the department. A Texas Yes! community member that is a city or county can submit a proposal on behalf of an event, festival or fair. The community member will be responsible for providing the sales tax information, other economic impact information, and any additional documentation or information requested by the department to indicate the impact of the project on the community or region. The department has the sole discretion to determine whether a project meets program eligibility requirements. A current Texas Yes! community member is limited to two approved projects for the biennium which begins September 1, 2005, and ends August 31, 2007.

Proposal Requirements. To apply for Texas Yes! Hometown STARS matching funds, a community member who is a city or county must: (i) prepare and submit a project request in accordance with this RFP; (ii) submit a sworn affidavit disclosing any existing or potential conflict of interest related to the evaluation of the project plan by the Texas Yes! Hometown STARS Review Team; and (iii) acknowledge that the applicant will notify the department of any change in the status of the project. The deadline for submission of project requests is January 13, 2006. The department will begin accepting applications on November 30, 2005, and will only consider the first twenty applications that it receives. The maximum amount of a project award is $10,000.00 per applicant.

Each project proposal must use the Texas Yes! Hometown STARS project proposal form, located on the Texas Yes! Web site at www.texasyes.org. Each project request submitted by an eligible applicant must describe the advertising or other market-oriented promotional activities to be carried out using matching funds and must include: (i) a cover page including the name, title and address of applicant and agent; (ii) a detailed specific narrative that contains a brief description of the community or city; a brief description of the tourism event that will be promoted; dates and location of the tourism event; why the applicant wants to promote the event; how the matching funds will be used to promote the tourism event; how the Texas Yes! Hometown STARS matching funds will improve the event; how the Texas Yes! program will be promoted as part of the promotional campaign; how the applicant will work with other entities to promote the event; what impact is expected from the event; and how the applicant will collect the necessary data to measure the impact of the promotion; (iii) a detailed budget/activity request; (iv) a signed original Resolution Authorizing Application from the governing body of the applicant; (v) a signed original Reimbursement Guidelines document; and (vi) a signed original Acknowledgement of proposal completion and receipt of the Reimbursement Guidelines. Please send one original for initial review by the Funding Coordinator and then follow up with 10 additional copies, when requested by the Funding Coordinator, that will be distributed to the Review Team.

All approved projects must not begin until March 15, 2006, at the earliest and must be completed by August 31, 2007, or the date specified in the project agreement, whichever is earlier. All purchasing of approved budget items and the actual events must occur within the agreement period. All approved projects will be subject to audit and periodic reporting requirements.

Proposals should be submitted to: Debbie Wall, Funding Coordinator, Texas Department of Agriculture, 1700 North Congress Avenue, 11th Floor, Austin, Texas 78701. Ms. Wall may be contacted by telephone at (512) 463-7731, by fax at 1-888-223-7045 or E-mail at debbie.wall@agr.state.tx.us for additional information about preparing the proposal.

All qualifying proposals will be evaluated by the Texas Yes! Hometown STARS Review Team, which is appointed by the Commissioner of Agriculture. The Texas Yes! Hometown STARS Review Team members are representatives from the following areas: media, print, travel industry, art, agricultural tourism, rural economic development, historical preservation, cultural diversity, entertainment industry, GO

TEXAN Partner Program, and awarded Texas Yes! communities. Proposals will be selected for reimbursement funding on a competitive basis. The proposals will be rated on ten general criteria by the Texas Yes! Hometown STARS Review Team. The ten criteria are as follows: (i) the proposal displays a well-planned vision for the tourism event promotion; (ii) the proposal presents concrete goals for this project; (iii) the proposal is unique and innovative; (iv) the anticipated results indicate a good return on investment; (v) the proposal includes efforts to effectively utilize regional resources; (vi) the event offers good potential to draw new and returning visitors from outside the area; (vii) the promotion will further enhance the Texas Yes! program with a high level of visibility for Texas Yes! (viii) the proposed budget is appropriate and well- developed; (ix) the proposal includes a well-conceived and tangible plan for impact measurement; and (x) based on the information in the proposal, the promoted event appears to have a high probability for success with room to expand and grow. The department's Texas Yes! Hometown STARS Review Committee will base its award decisions on the Texas Yes! Hometown STARS Review Team's recommendations and each applicant's overall score. The factors that the department will consider when evaluating each application are subject to change, without notice, at the discretion of the department.

Only project requests that further or enhance the department's Texas Yes! Program and are submitted by applicants physically located in Texas will be funded. The department reserves the right to terminate any award if it determines, in its sole discretion, that a project does not further or enhance the goals of the Texas Yes! Program.

The program is subject to the availability of state funds. If such funds become unavailable during the term of the program and the department is unable to obtain sufficient funds, the program and any agreements shall be reduced or terminated.

The announcement of the grant awards will be made by the Funding Coordinator after the first twenty applications received by the department have been fully considered.

TRD-200505418
Dolores Alvarado Hibbs
Deputy General Counsel
Texas Department of Agriculture
Filed: November 21, 2005

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Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of November 4, 2005, through November 10, 2005. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for these activities extends 30 days from the date published on the Coastal Coordination Council web site. The notice was published on the web site on November 23, 2005. The public comment period for these projects will close at 5:00 p.m. on December 27, 2005.

FEDERAL AGENCY ACTIONS:

Applicant: Alana Mora, A. A. Mora, and Robin King; Location: The project is located in Port Aransas Municipal Harbor, at 154 West Cotter Avenue, Port Aransas, Nueces County. The project can be located on the U.S.G.S. quadrangle map entitled: Port Aransas, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 14; Easting: 690500; Northing: 3080850. Project Description: The applicant proposes to place fill into an existing boat slip that is approximately 26 feet wide by 100 feet long (0.05 acres), with a water depth of -4 feet mean low tide. The slip was excavated from uplands and has a bulkhead on three sides. The slip is no longer needed and the applicants would like to maximize the buildable land area of the property. First, a bulkhead would be installed across the opening of the slip, with turbidity curtains used throughout the bulkhead installation procedure to maximize impacts to water quality. After construction of the bulkhead at the slip opening, approximately 150,000 gallons of water would be pumped out of the slip and returned to the harbor. Finally, the slip would then be filled with 675 cubic yards of material to match the elevation of the remainder of the property. The site does not contain oysters or seagrasses. CCC Project No.: 06-0055-F1; Type of Application: U.S.A.C.E. permit application #23944 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Davis Petroleum Corporation; Location: The project is located in Galveston Bay, approximately 3 miles southeast of San Leon, in State Tracts (ST's) 329, 328, 327, and 333, in Galveston County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Texas City, Texas. Approximate UTM Coordinates in NAD 27 (meters) of all proposed components: 1) Well #1 ST 329 and beginning point of pipelines: Zone 15; Easting: 317540.53; Northing: 3261964.39; 2) Pipeline Route "A" (west) pivots at 49+04 in ST 328; Zone 15; Easting: 317712.640; Northing: 3260479.359 and ties in to an existing Transtexas pipeline in ST 333 at 67+72: Zone 15; Easting: 317443.272; Northing: 3259977.951; and 3) Pipeline Route "B" (east) pivots at 47+58 in ST 328; Zone 15; Easting: 318069.982; Northing: 3260613.915 and ties in to an existing Kinder-Morgan pipeline in ST 327 at 103+52; Zone 15; Easting: 319642.225; Northing: 3259953.416. Project Description: The applicant proposes to drill ST 329 Well #1 in search for oil and gas in ST 329, Galveston Bay, Galveston County, Texas. Such activities include installation of typical marine barges and keyways, production structures with attendant facilities, and flowlines. The applicant also proposes to install two pipelines up to 6 inches in diameter from the aforementioned proposed well. The first pipeline (Pipeline Route "A") would tie in to an existing Transtexas Gas pipeline in ST 333. The second pipeline (Pipeline Route "B") would run to an existing Kinder-Morgan pipeline in ST 327. There is a possibility that only one of the two pipelines would be installed. Approximately 10,200 cubic yards of material would be displaced during construction for both pipelines by trenching or jetting. Approximately 2,667 cubic yards of shell, gravel, or crush rock would be deposited to construct a 240 by 100 by 3-foot drilling pad. A Side Scan Sonar survey of the proposed well and pipelines sites was conducted. An area within a 500-foot radius was surveyed around the proposed well location and no oysters or reefs were found. A survey was also conducted for each proposed pipeline from the centerline out 500 feet on both sides, and no oysters or reefs were found except where shown on the plans. CCC Project No.: 06-0058-F1; Type of Application: U.S.A.C.E. permit application #23974 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Railroad Commission under §401 of the Clean Water Act.

Applicant: Davis Petroleum Corporation; Location: The project is located in Galveston Bay, approximately 3 miles southeast of San Leon, in State Tracts (ST's) 262, 288, 287, 308, 330, and 331, Galveston and Chambers Counties, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Bacliff, Texas. Approximate UTM Coordinates in NAD 27 (meters) of all proposed components: 1) Well #1 ST 308 and beginning point of both proposed pipelines: Zone 15; Easting: 3265166.81; Northing: 315485.77; 2) Pipeline Route "A" runs from the proposed well to northwest of Eagle Point. The pipeline pivots at 22+74 in ST 308; Zone 15, Easting: 315144.400; Northing: 3265770.149 and continues to 109+105 in ST 288, Zone 15, Easting: 314509.892; Northing: 3268323.556; where it pivots and runs on to tie in to an existing 8-inch Davis pipeline in ST 262, at 140+66; UTM 15, Easting: 315040.012; Northing: 3269128.392; 3) Pipeline Route "B" runs from the proposed well to southeast of Eagle Point. A portion of this pipeline is bored. The pipeline pivots at 34+22 in ST 308; Zone 15, Easting: 315104.920; Northing: 3264195.560 and continues to 138+05 in ST 331, Zone 15, Easting: 314874.814; Northing: 3261038.889; where it stops at the existing National Onshore LP platform (formerly Transtexas Gas Corporation). Project Description: The applicant proposes to drill ST 308 Well #1 in search of oil and gas in ST 308, Galveston Bay in Galveston County, Texas. Such activities include installation of typical marine barges and keyways, production structures with attendant facilities, and flowlines. The applicant also proposes to install 2 pipelines (Routes "A" and "B"). Route "A" begins from said well and ends to the northwest at a tie-in point on an existing 8-inch pipeline in ST 262. Route "B" also begins from said well and traverses in a southeast direction to an existing National Onshore LP platform in ST 331. Such activities include installation of typical marine barges and keyways production structures with attendant facilities, and flowlines. No pads would be installed. CCC Project No.: 06-0059-F1; Type of Application: U.S.A.C.E. permit application #23978 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Railroad Commission under §401 of the Clean Water Act.

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above may be obtained from Ms. Tammy Brooks, Program Specialist, Coastal Coordination Council, P. O. Box 12873, Austin, Texas 78711-2873, or tammy.brooks@glo.state.tx.us. Comments should be sent to Ms. Brooks at the above address or by fax at (512) 475-0680.

TRD-200505377
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: November 21, 2005

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.009, and 304.003, Tex. Fin. Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/28/05 - 12/04/05 is 18% for Consumer [1]/Agricultural/Commercial [2]/credit thru $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/28/05 - 12/04/05 is 18% for Commercial over $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 12/01/05 - 12/31/05 is 7.00% for Consumer/Agricultural/Commercial/credit thru $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 12/01/05 - 12/31/05 is 7.00% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment, or other similar purpose.

TRD-200505414
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: November 21, 2005

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Texas Education Agency

Request for eGrant Applications Concerning Public Charter Schools Start-up Grant, Cycle 11

Eligible Applicants. The Texas Education Agency (TEA) is requesting eGrant applications under Standard Application System (SAS) CHARAB06 from newly approved open-enrollment charter schools established by Texas Education Code (TEC), Subchapter D, to provide initial start-up funding for planning and/or implementing charter school activities. Campus charters established by TEC, Subchapter C, that meet the federal definition of a charter school and that have never received start-up grant funds are also eligible to apply.

Description. In accordance with the purpose of the federal Public Charter Schools Start-Up Grant Program, funds may be used for post-award planning and design of the charter school's educational program, which may include refining the desired educational results and methods for measuring progress toward achieving those results and providing professional development for teachers and other staff who will work in the public charter school. Funds may also be used for the initial implementation of the charter school, which may include: (1) informing the community about the public charter school; (2) acquiring necessary equipment and educational materials and supplies; (3) acquiring or developing curriculum materials; and (4) funding other initial operational costs that cannot be met from state or local sources.

Dates of Project. The Public Charter Schools Start-Up Grant, Cycle 11, will be implemented during the 2005-2006 and 2006-2007 school years. Applicants should plan for a starting date of no earlier than February 1, 2006, and an ending date of no later than January 31, 2007.

Project Amount. Funding will be provided for approximately 16 projects. Each project will receive a maximum of $250,000 for the grant period. Continuation funding will be based on satisfactory progress of the first-year objectives and activities and on general budget approval by the commissioner of education and appropriations by the U. S. Congress. This project is funded 100 percent from Public Charter Schools federal funds.

The TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this SAS. This SAS does not commit TEA to pay any costs before an application is approved. The issuance of this SAS does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Obtaining Access to TEA's eGrants. The Public Charter School Start-Up Grant, Cycle 11, is available only through TEA's eGrants and may not be obtained or submitted by any other means. The eGrant application will be available in eGrants beginning December 2, 2005. All eGrant users must have a TEASE user name and password. To apply for access to eGrants, go to http://www.tea.state.tx.us/opge/egrant/index.html. Under the "eGrants Toolbox," select "External Users: Apply for eGrants Logon." Complete the form as instructed, obtain the required signatures, and send it to the TEA contact listed on the form.

Further Information. For clarifying information about the eGrant SAS, contact Donnell Bilsky, Division of Discretionary Grants, Texas Education Agency, (512) 463-9269.

Deadline for Receipt of eGrant Applications. Applications must be received by the Texas Education Agency by 5:00 p.m. (Central Time), Tuesday, January 17, 2006, to be considered for funding.

TRD-200505463
Cristina de La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: November 23, 2005

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Employees Retirement System of Texas

Request for Proposal for Drug Importation Program Study

In accordance with Article IX, Section 10.09 of the General Appropriations Act ("Drug Cost Study"), 79th Texas Legislature, Regular Session, the Employees Retirement System of Texas ("ERS") is issuing a Request for Proposal ("RFP") for a Qualified Consultant to conduct a Statewide Drug Cost Containment Strategy and provide a detailed cost-effectiveness and feasibility study for implementing a prescription drug importation program. The contract will begin immediately upon its execution by ERS, and will extend through completion of the services as specified in Article III of the RFP, unless terminated as provided in the contract. The contract expands upon this provision. The consultant shall provide the level of services required in the RFP and meet all other proposal requirements.

The RFP will be available on or after November 30, 2005 from ERS' Website. To access the RFP from the website, interested consultants must either fax their request on their company letterhead to the attention of Araceli Garcia at (512) 867-3380, or send their request via email to araceli.garcia@ers.state.tx.us to receive their access code. Either request must include the name of the consultant, street address, phone number, fax number, and email address, if applicable.

To be eligible for consideration, the consultant is required to submit one (1) original sealed proposal with the fully executed contract, signed in blue ink and without amendment or revision, with all required completed exhibits attached, and three (3) printed copies of the proposal including all required exhibits, and one (1) additional proposal copied on a CD. All materials must be executed as noted above and must be received by ERS as specified in Article I.B.5. of the RFP.

ERS will base its evaluation and selection of the consultant on factors including, but not limited to the following, which are not necessarily listed in order of priority: compliance with the RFP, experience evaluating and reporting on drug importation and large prescription drug programs, fee proposals, and other relevant criteria as determined by ERS. Each proposal will be individually evaluated relative to other consultants. Complete specifications will be included with the RFP.

ERS reserves the right to reject any or all proposals and call for new proposals if deemed by ERS to be in the best interests of the study participants and the state of Texas. ERS also reserves the right to reject any proposal submitted that does not fully comply with the RFP's instructions and criteria. ERS is under no legal requirement to execute a contract on the basis of this notice or upon issuance of the RFP.

ERS will not pay any costs incurred by any entity in responding to this notice or the RFP or in connection with the preparation thereof. ERS specifically reserves the right to vary all provisions set forth at any time prior to execution of a contract where ERS deems it to be in the best interest of the study participants and the state of Texas.

TRD-200505375
Ann S. Fuelberg
Executive Director
Employees Retirement System of Texas
Filed: November 18, 2005

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Texas Commission on Environmental Quality

Enforcement Orders

A default order was entered regarding Ruben's Vacuum & Hydrojetting Services, Inc., Docket No. 2002-1131-SLG-E on 11/14/2005 assessing $14,510 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Gitanjali Yadav, Staff Attorney, at (512) 239-2029, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Joe Jenkins dba J & M Total Land Care, Docket No. 2003-1396-LII-E on 11/14/2005 assessing $3,313 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kathleen Decker, Staff Attorney, at (512) 239-6500, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Houston, Docket No. 2002-0555-MWD-E on 11/14/2005 assessing $969,195 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Pamela Campbell, Enforcement Coordinator, at (512) 239-4493, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chevron Phillips Chemical Company LP, Docket No. 2003-0646-AIR-E on 11/14/2005 assessing $51,816 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting David Flores, Enforcement Coordinator, at (512) 239-1165, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Navi Food and Fuel L.L.C. dba Navi Food & Fuel, Docket No. 2003-0194-PST-E on 11/14/2005 assessing $9,000 in administrative penalties with $7,800 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator, at (210) 403-4006, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Dhanani Investment, Inc. dba Yale Shamrock, Docket No. 2004-0369-PST-E on 11/15/2005 assessing $24,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kathleen Decker, Staff Attorney, at (512) 239-6500, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Sardinia, Inc. dba Market Ace 4, Docket No. 2004-0671-PST-E on 11/16/2005 assessing $21,150 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Amie Richardson, Staff Attorney, at (512) 239-2999, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of South Houston, Docket No. 2004-0722-MWD-E on 11/14/2005 assessing $20,000 in administrative penalties .

Information concerning any aspect of this order may be obtained by contacting Audra Ruble, Enforcement Coordinator, at (361) 825-3126, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Alex Mair dba Mair Rentals, Docket No. 2004-0909-PWS-E on 11/15/2005 assessing $3,350 in administrative penalties with $670 deferred.

Information concerning any aspect of this order may be obtained by contacting Audra Ruble, Enforcement Coordinator, at (361) 825-3126, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of New Summerfield, Docket No. 2004-1082-MWD-E on 11/14/2005 assessing $3,340 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Laurie Eaves, Enforcement Coordinator, at (512) 239-4495, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Salado Quarry, Inc., Docket No. 2004-1102-WQ-E on 11/15/2005 assessing $7,500 in administrative penalties with $1,500 deferred.

Information concerning any aspect of this order may be obtained by contacting Brian Lehmkuhle, Enforcement Coordinator, at (512) 239-4482, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Houston, Docket No. 2004-1136-AIR-E on 11/14/2005 assessing $40,348 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jaime Garza, Enforcement Coordinator, at (956) 430-6030, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Brant-Sta Inc. dba Max A Mart, Docket No. 2004-1147-PST-E on 11/15/2005 assessing $5,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Courtney St. Julian, Staff Attorney, at (512) 239-0617, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Smartway, Inc. dba Roadrunner Food Mart, Docket No. 2004-1149-PST-E on 11/15/2005 assessing $8,800 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Xavier Guerra, Staff Attorney, at (210) 490-3096, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding West Side Storage, Inc., Docket No. 2004-1404-MSW-E on 11/14/2005 assessing $3,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kent Heath, Enforcement Coordinator, at (512) 239-4575, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Wilbarger County, Docket No. 2004-1486-PST-E on 11/15/2005 assessing $9,500 in administrative penalties with $1,900 deferred.

Information concerning any aspect of this order may be obtained by contacting A. Sunday Udoetok, Enforcement Coordinator, at (512) 239-0739, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding R. D. Wallace Oil Co., Inc. dba Petro Products Corporation dba Keeling Card System, Docket No. 2004-1514-PST-E on 11/15/2005 assessing $2,040 in administrative penalties with $408 deferred.

Information concerning any aspect of this order may be obtained by contacting Kent Heath, Enforcement Coordinator, at (512) 239-4575, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Buford West dba Genie Car Care Center of Hewitt and Leah West dba Genie Car Care Center of Hewitt, Docket No. 2004-1557-PST-E on 11/15/2005 assessing $2,140 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kathleen Decker, Staff Attorney, at (512) 239-6500, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Hearne, Docket No. 2004-1579-MWD-E on 11/14/2005 assessing $12,675 in administrative penalties with $2,535 deferred.

Information concerning any aspect of this order may be obtained by contacting Elvia Maske, Enforcement Coordinator, at (512) 239-0789, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Gunter, Docket No. 2004-1856-MWD-E on 11/14/2005 assessing $15,900 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, Enforcement Coordinator, at (817) 588-5890, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Houston, Docket No. 2004-2080-MWD-E on 11/16/2005 assessing $17,500 in administrative penalties with $3,500 deferred.

Information concerning any aspect of this order may be obtained by contacting Pamela Campbell, Enforcement Coordinator, at (512) 239-4493, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding KTC Investment, Inc. dba Kamman's CITGO, Docket No. 2004-2083-PST-E on 11/14/2005 assessing $3,150 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Howard Willoughby, Enforcement Coordinator, at (361) 825-3140, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Onyx Environmental Services, LLC, Docket No. 2005-0039-IHW-E on 11/14/2005 assessing $6,400 in administrative penalties with $1,280 deferred.

Information concerning any aspect of this order may be obtained by contacting Harvey Wilson, Enforcement Coordinator, at (512) 239-0321, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding IU Merger Sub, Inc., Docket No. 2005-0079-MWD-E on 11/14/2005 assessing $5,000 in administrative penalties with $1,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Meyer, Enforcement Coordinator, at (512) 239-4492, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Airtex Investments, Inc. dba Time Mart 10, Docket No. 2005-0081-PST-E on 11/15/2005 assessing $2,180 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kathleen Decker, Staff Attorney, at (512) 239-6500, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding C & R Distributing, Inc., Docket No. 2005-0103-PST-E on 11/14/2005 assessing $3,750 in administrative penalties with $750 deferred.

Information concerning any aspect of this order may be obtained by contacting Sandy VanCleave, Enforcement Coordinator, at (512) 239-0667, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ronnie Callahan, Docket No. 2005-0130-MSW-E on 11/14/2005 assessing $2,500 in administrative penalties with $500 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator, at (817) 588-5825, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Angela Ellis dba Ellis Auto Detailing, Docket No. 2005-0194-MSW-E on 11/14/2005 assessing $2,730 in administrative penalties with $546 deferred.

Information concerning any aspect of this order may be obtained by contacting Tom Greimel, Enforcement Coordinator, at (512) 239-5690, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Amil Enterprises Inc. dba Sunny's Mini Mart, Docket No. 2005-0197-PST-E on 11/15/2005 assessing $1,600 in administrative penalties with $320 deferred.

Information concerning any aspect of this order may be obtained by contacting Howard Willoughby, Enforcement Coordinator, at (361) 825-3140, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Celanese Ltd., Docket No. 2005-0213-AIR-E on 11/14/2005 assessing $5,050 in administrative penalties with $1,010 deferred.

Information concerning any aspect of this order may be obtained by contacting Laurie Eaves, Enforcement Coordinator, at (512) 239-4495, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Richard and Rebecca Reed dba R & R Reed Recycling, Docket No. 2005-0265-MLM-E on 11/14/2005 assessing $20,910 in administrative penalties with $4,182 deferred.

Information concerning any aspect of this order may be obtained by contacting Craig Fleming, Enforcement Coordinator, at (512) 239-5806, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Dan Chorenziak dba Dutchman's Hidden Valley Store, Docket No. 2005-0328-PWS-E on 11/15/2005 assessing $1,296 in administrative penalties with $259 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Meyer, Enforcement Coordinator, at (512) 239-4492, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Phelps Dodge Corporation, Docket No. 2005-0390-AIR-E on 11/14/2005 assessing $2,250 in administrative penalties with $450 deferred.

Information concerning any aspect of this order may be obtained by contacting John Barry, Enforcement Coordinator, at (409) 899-8781, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Convenience Management Services, Inc. dba CMSI 301, Docket No. 2005-0398-PST-E on 11/15/2005 assessing $8,100 in administrative penalties with $1,620 deferred.

Information concerning any aspect of this order may be obtained by contacting Kent Heath, Enforcement Coordinator, at (512) 239-4575, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Silver Creek Lodge, Marina, and Yacht Club Incorporated, Docket No. 2005-0430-MWD-E on 11/14/2005 assessing $7,995 in administrative penalties with $1,599 deferred.

Information concerning any aspect of this order may be obtained by contacting Joseph Daley, Enforcement Coordinator, at (512) 239-3308, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding The Lighted Fishing Pier, LLC, Docket No. 2005-0439-PWS-E on 11/15/2005 assessing $1,525 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting J. Mac Vilas, Enforcement Coordinator, at (512) 239-2557, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Alon USA, LP, Docket No. 2005-0449-AIR-E on 11/14/2005 assessing $13,600 in administrative penalties with $2,720 deferred.

Information concerning any aspect of this order may be obtained by contacting Harvey Wilson, Enforcement Coordinator, at (512) 239-

0321, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Westphalia Water & Sewer Supply Corporation, Docket No. 2005-0496-MWD-E on 11/14/2005 assessing $3,410 in administrative penalties with $682 deferred.

Information concerning any aspect of this order may be obtained by contacting Joseph Daley, Enforcement Coordinator, at (512) 239-3308, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Paint Rock Independent School District, Docket No. 2005-0504-PST-E on 11/15/2005 assessing $2,600 in administrative penalties with $520 deferred.

Information concerning any aspect of this order may be obtained by contacting Shontay Wilcher, Enforcement Coordinator, at (512) 239-2136, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Boyd, Docket No. 2005-0507-PWS-E on 11/15/2005 assessing $1,650 in administrative penalties with $330 deferred.

Information concerning any aspect of this order may be obtained by contacting Craig Fleming, Enforcement Coordinator at (512) 239-5806, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Texas A & M University, Docket No. 2005-0578-MWD-E on 11/14/2005 assessing $14,400 in administrative penalties with $2,880 deferred.

Information concerning any aspect of this order may be obtained by contacting Steven Lopez, Enforcement Coordinator, at (512) 239-1896, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Angleton, Docket No. 2005-0592-MWD-E on 11/14/2005 assessing $4,960 in administrative penalties with $992 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Meyer, Enforcement Coordinator, at (512) 239-4492, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Red River Authority of Texas, Docket No. 2005-0594-MWD-E on 11/14/2005 assessing $1,720 in administrative penalties with $344 deferred.

Information concerning any aspect of this order may be obtained by contacting Pamela Campbell, Enforcement Coordinator, at (512) 239-4493, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SK Integrated, Inc. dba Evan's Stop N Go, Docket No. 2005-0616-PST-E on 11/15/2005 assessing $2,400 in administrative penalties with $480 deferred.

Information concerning any aspect of this order may be obtained by contacting Howard Willoughby, Enforcement Coordinator, at (361) 825-3140, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Muhammad Aslam dba Convenient Food Mart, Docket No. 2005-0620-PST-E on 11/14/2005 assessing $2,500 in administrative penalties with $500 deferred.

Information concerning any aspect of this order may be obtained by contacting Ruben Soto, Enforcement Coordinator, at (512) 239-4571, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Brookshire Mwd, Docket No. 2005-0647-MWD-E on 11/14/2005 assessing $4,420 in administrative penalties with $884 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Meyer, Enforcement Coordinator, at (512) 239-4492, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Syed N. Hyder, Docket No. 2005-0648-MWD-E on 11/14/2005 assessing $5,720 in administrative penalties with $1,144 deferred.

Information concerning any aspect of this order may be obtained by contacting Tom Greimel, Enforcement Coordinator, at (512) 239-5690, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Sultan M. Mohmand dba M & M Food Mart, Docket No. 2005-0660-PST-E on 11/15/2005 assessing $2,850 in administrative penalties with $570 deferred.

Information concerning any aspect of this order may be obtained by contacting A. Sunday Udoetok, Enforcement Coordinator, at (512) 239-0739, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Paint Rock, Docket No. 2005-0684-PWS-E on 11/15/2005 assessing $560 in administrative penalties with $112 deferred.

Information concerning any aspect of this order may be obtained by contacting Brent Hurta, Enforcement Coordinator, at (512) 239-6589, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding S.K. Master, Inc. dba A J Food Mart, Docket No. 2005-0691-PST-E on 11/15/2005 assessing $2,970 in administrative penalties with $594 deferred.

Information concerning any aspect of this order may be obtained by contacting Pamela Campbell, Enforcement Coordinator, at (512) 239-4493, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Sun Valley Distribution, Inc., Docket No. 2005-0735-PST-E on 11/15/2005 assessing $10,710 in administrative penalties with $2,142 deferred.

Information concerning any aspect of this order may be obtained by contacting Steven Lopez, Enforcement Coordinator, at (512) 239-1896, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Akber Berani dba Kwik Stop Conoco, Docket No. 2005-0760-PST-E on 11/15/2005 assessing $11,220 in administrative penalties with $2,244 deferred.

Information concerning any aspect of this order may be obtained by contacting Brent Hurta, Enforcement Coordinator, at (512) 239-6589, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Pendleton Utility Corp., Docket No. 2005-0764-PWS-E on 11/15/2005 assessing $645 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting John Muennink, Enforcement Coordinator, at (361) 825-

3423, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Marshall, Docket No. 2005-0799-PWS-E on 11/15/2005 assessing $1,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kimberly Morales, Enforcement Coordinator, at (713) 422-8938, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ashland Inc., Docket No. 2005-0817-AIR-E on 11/14/2005 assessing $3,000 in administrative penalties with $600 deferred.

Information concerning any aspect of this order may be obtained by contacting Merrilee Hupp, Enforcement Coordinator, at (512) 239-4490, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Hydrodynamics, Incorp. dba Associated Fiberglass Enterprises, Docket No. 2005-0831-AIR-E on 11/16/2005 assessing $2,550 in administrative penalties with $510 deferred.

Information concerning any aspect of this order may be obtained by contacting A. Sunday Udoetok, Enforcement Coordinator, at (512) 239-0739, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding B. Rainey & Son Enterprises, Inc. dba Family Mart 3, Docket No. 2005-0860-PST-E on 11/15/2005 assessing $4,500 in administrative penalties with $900 deferred.

Information concerning any aspect of this order may be obtained by contacting Deana Holland, Enforcement Coordinator, at (512) 239-2504, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Early, Docket No. 2005-0903-PWS-E on 11/15/2005 assessing $655 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jill McNew, Enforcement Coordinator, at (512) 239-0560, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding T. W. E. Enterprises, Inc., Docket No. 2005-0915-PWS-E on 11/15/2005 assessing $1,120 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kimberly Morales, Enforcement Coordinator, at (713) 422-8938, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ashfaq Ahmed dba Texaco - A K Food Mart, Docket No. 2005-0942-PST-E on 11/15/2005 assessing $1,170 in administrative penalties with $234 deferred.

Information concerning any aspect of this order may be obtained by contacting Howard Willoughby, Enforcement Coordinator, at (361) 825-3140, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Woodmere Development Co., Ltd., Docket No. 2005-1028-AIR-E on 11/14/2005 assessing $2,000 in administrative penalties with $400 deferred.

Information concerning any aspect of this order may be obtained by contacting Kimberly Morales, Enforcement Coordinator, at (713) 422-8938, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Cooper, Docket No. 2005-1056-PWS-E on 11/15/2005 assessing $368 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jill McNew, Enforcement Coordinator, at (512) 239-0560, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Turtle Cove Lot Owners Association, Inc., Docket No. 2005-1099-PWS-E on 11/15/2005 assessing $280 in administrative penalties with $56 deferred.

Information concerning any aspect of this order may be obtained by contacting Amanda King- Zrubek, Enforcement Coordinator, at (512) 239-0824, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Thomas A. Kalina, Docket No. 2005-1117-OSI-E on 11/14/2005 assessing $188 in administrative penalties with $38 deferred.

Information concerning any aspect of this order may be obtained by contacting Joseph Daley, Enforcement Coordinator, at (512) 239-3308, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Mount Vernon, Docket No. 2005-1121-PWS-E on 11/15/2005 assessing $343 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Harvey Wilson, Enforcement Coordinator, at (512) 239-0321, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City Of Kemp, Docket No. 2005-1135-PWS-E on 11/15/2005 assessing $645 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rebecca Johnson, Enforcement Coordinator, at (713) 422-8931, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Crosby Mud, Docket No. 2005-1159-PWS-E on 11/15/2005 assessing $12,90 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator, at (210) 403-4006, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Wills Point, Docket No. 2005-1179-PWS-E on 11/15/2005 assessing $1,310 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Craig Fleming, Enforcement Coordinator, at (512) 239-5806, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Mart, Docket No. 2005-1219-PWS-E on 11/15/2005 assessing $1,470 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jill McNew, Enforcement Coordinator, at (512) 239-0560, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding U.S. Silica Company, Docket No. 2005-1282-AIR-E on 11/14/2005 assessing $7,650 in administrative penalties with $1,530 deferred.

Information concerning any aspect of this order may be obtained by contacting Craig Fleming, Enforcement Coordinator, at (512) 239-5806, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Paris Car Care, L.L.C. dba Quick & E-Z Lube, Docket No. 2005-1315-PST-E on 11/15/2005 assessing $1,050 in administrative penalties with $210 deferred.

Information concerning any aspect of this order may be obtained by contacting Shontay Wilcher, Enforcement Coordinator, at (512) 239-2136, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Abubaker Yusuf dba Texaco Service Station, Docket No. 2005-0453-PST-E on 11/15/2005 assessing $11,730 in administrative penalties with $2,346 deferred.

Information concerning any aspect of this order may be obtained by contacting Cheryl Thompson, Enforcement Coordinator, at (817) 588-5886, Texas Commission on Environmental Quality, P. O. Box 13087, Austin, Texas 78711-3087.

TRD-200505464
LaDonna Castanuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 23, 2005

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Notice of Meeting in San Angelo Concerning the San Angelo Electric Services Company Facility

The purpose of the meeting is to obtain public input and information concerning: proposal of the facility to the state registry of Superfund sites; the identification of potentially responsible parties; and the proposal of non-residential land use.

The Texas Commission on Environmental Quality (TCEQ) is required under Texas Health and Safety Code, Chapter 361, Solid Waste Disposal Act (the Act) to annually publish a state registry that identifies facilities that may constitute an imminent and substantial endangerment to public health and safety or the environment due to a release or threatened release of hazardous substances into the environment. The most recent registry listing of these facilities was published in the March 26, 2004, issue of the *Texas Register* (29 TexReg 3278).

Under the Act, §361.184(a), the TCEQ must publish a notice of intent to list a facility on the state registry of Superfund sites in the *Texas Register* and in a newspaper of general circulation in the county in which the facility is located. With this publication, the TCEQ is giving notice that the agency is proposing to list the San Angelo Electric Services Company (SESCO) facility on the state registry. By this publication, the TCEQ is also giving notice under the Act, §361.1855 that it proposes a land use other than residential as appropriate for the facility. The TCEQ is proposing a land use designation of commercial/industrial based on the existing land use of the property, as is prescribed in 30 TAC §350.53, Land Use Classification. Determination of appropriate land use may impact the remedial investigation and remedial action for the site.

This publication also specifies the general nature of the potential endangerment to public health and safety or the environment as determined by information currently available to the TCEQ. This notice was also published on December 2, 2005, in the *San Angelo Standard Times*.

The SESCO facility is located at 926 Pulliam Street between Browning Street and the AT & SF Railroad in San Angelo, Tom Green County, Texas. The geographic coordinates of the site are 31 degrees, 28 minutes, 15.2 seconds, North Latitude and 100 degrees, 25 minutes, 19.4 seconds, West Longitude. The description of the facility is based on information available at the time the facility was evaluated with the Hazard Ranking System (HRS). The HRS is the principal screening tool used by the TCEQ to evaluate potential, relative risk to public health and the environment from releases or threatened releases of hazardous substances. The description of the facility may change as additional information is gathered on the sources and extent of contamination.

The SESCO facility covers approximately six acres and has been in commercial/industrial use since 1946. Land use around the facility is mixed residential and commercial/industrial. The San Jacinto Elementary School is located across Pulliam Street, south of the facility.

SESCO began operation on the property in 1946. The company built, repaired, and serviced electrical transformers and other electrical equipment at this site. SESCO declared bankruptcy and went out of business in August of 2003. In response to documented releases at the facility, TCEQ collected and analyzed both soil and groundwater samples from the facility and adjacent properties during the spring of 2003. Polychlorinated biphenyls (PCBs), a hazardous man-made electrical insulating fluid once used in transformers, were discovered in the soil and groundwater both on and off the SESCO property. Based on these sample results, in combination with sample results from investigations previously conducted by SESCO, TCEQ conducted an emergency removal. The emergency removal included excavating off-site contaminated soils in residential yards, an alley along North Browning Street, the northernmost portion of the San Jacinto Elementary School's soccer field along Pulliam Street, and portions of the SESCO property outside of the fence line. Shortly after the soil removal, all remaining transformers were removed from the site. In addition to soil removal activities, TCEQ began operating and maintaining a pump and treatment system that SESCO had installed to pump contaminated groundwater at the facility, filter it through an oil/water separator, and then discharge the clean water to the city's sanitary sewer system.

In December of 2004, a group of potentially responsible parties (SESCO Site Working Group) signed an interim agreement with the TCEQ. At that time, the SESCO Site Working Group voluntarily took over interim operation and maintenance of the groundwater treatment system, and monitoring and security responsibilities for the SESCO facility. Currently, the facility is fenced and has warning signs posted. Approximately one-third of the facility area is paved. Multiple buildings are present as well as a number of 55-gallon drums containing nuts, bolts, ceramic insulators, and other parts that SESCO used in its day-to-day operations, a few drums containing waste materials as indicated by their labels, and multiple aboveground storage tanks. PCB contamination is still present and needs to be remediated in both soil and groundwater at the facility.

A public meeting will be held on Thursday, January 12, 2006, at 7:00 p.m. at the San Jacinto Elementary School cafeteria, 800 Spaulding in San Angelo, Texas. The purpose of this meeting is to obtain additional information regarding the site relative to its eligibility for listing on the state registry, to identify additional potentially responsible parties, and to obtain public input and information regarding the appropriate use of land on which the facility is located. The public meeting will be

legislative in nature and not a contested case hearing under Texas Government Code, Chapter 2001, Texas Administrative Procedure Act.

All persons desiring to make comments may do so prior to or at the public meeting. All comments submitted **prior** to the public meeting must be received by 5:00 p.m., January 12, 2006, **and should be sent** to Sarah Schreier, Project Manager, TCEQ, Remediation Division, MC 136, P.O. Box 13087, Austin, Texas 78711-3087 or by facsimile at (512) 239-2450. The public comment period for this action will end at the close of the public meeting on January 12, 2006.

A portion of the record for this site, including documents pertinent to the facility's eligibility for the state registry, is available for review at the Tom Green County Public Library, Main Branch, 113 West Beauregard Avenue, San Angelo, Texas 76903, (325) 655-7321 during regular business hours. Copies of the complete public record file may be obtained during regular business hours at the TCEQ's Records Management Center, Records Customer Service, Building E, First Floor, 12100 Park 35 Circle, Austin, Texas 78753, (800) 633-9363 or (512) 239-2920. Photocopying of file information is subject to payment of a fee. Parking is available on the east side of Building D, convenient to access ramps that are between Buildings D and E.

Information regarding the state Superfund program is also available at *http://www.tceq.state.tx.us/remediation/programs.html*.

Persons who have special communication or other accommodation needs who are planning to attend the meeting should contact the agency at (800) 633-9363 or (512) 239-2463. Requests should be made as far in advance as possible.

For further information about this site or the public meeting, please call Bruce McAnally, TCEQ Community Relations, at (800) 633-9363, extension 2141.

TRD-200505437

Stephanie Bergeron Perdue

Director, Environmental Law Division

Texas Commission on Environmental Quality

Filed: November 22, 2005

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission in accordance with Texas Water Code (TWC), §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 2, 2006**. The commission will consider any written comments received and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate a proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 2, 2006**. Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, comments on the DOs should be submitted to the commission in **writing**.

(1) COMPANY: Brenda Ledbetter dba Potters Creek Store; DOCKET NUMBER: 2004-1817-PST- E; TCEQ ID NUMBERS: 39903 and RN102456985; LOCATION: 2881 Potters Creek Road, Canyon Lake, Comal County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum underground storage tanks (USTs); PENALTY: $3,150; STAFF ATTORNEY: Xavier Guerra, Litigation Division, MC R-13, (210) 403-4016; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(2) COMPANY: David Williams dba Shelby Trash Service; DOCKET NUMBER: 2004-0950- MSW-E; TCEQ ID NUMBER: RN103000055; LOCATION: 3536 State Highway 7, Center, Shelby County, Texas; TYPE OF FACILITY: municipal solid waste site; RULES VIOLATED: 30 TAC §330.5(a), by failing to properly dispose of municipal solid waste at an authorized site; PENALTY: $2,625; STAFF ATTORNEY: Shannon Strong, Litigation Division, MC 175, (512) 239-0972; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(3) COMPANY: Don English dba English Acres; DOCKET NUMBER: 2005-0238-PWS-E; TCEQ ID NUMBERS: 1250033 and RN102670783; LOCATION: off of Highway 44 at the intersection of Farm-to-Market Road 1554 and County Road 136, west of Alice, Jim Wells County, Texas; TYPE OF FACILITY: public water system facility; RULES VIOLATED: 30 TAC §290.45(b)(1)(F)(iv), by failing to provide a pressure tank capacity of 20 gallons per connection; 30 TAC §290.43(c)(3), by failing to provide the ground storage tank with an access ladder and proper overflow pipe as specified in current American Water Works Association standards; 30 TAC §290.41(c)(3)(O) and §290.43(e), by failing to provide the well unit with intruder-resistant fences with locked gates or enclosing the well unit in a locked, ventilated well house to exclude possible contamination or damage to the facility by trespassers, and by failing to enclose the pressure tank and ground storage tank with an intruder-resistant fence with lockable gates; 30 TAC §290.46(m)(4) and (v), by failing to maintain all water treatment units, storage, and pressure maintenance facilities, distribution system lines, and related appurtenances in a watertight condition and by failing to ensure that all water system electrical wiring was securely installed in compliance with a local or national electrical code; 30 TAC §290.46(f), by failing to maintain a record of water works operation and maintenance activities including results of inspections, microbiological analyses, amount of chemicals used, volume of water treated, water quality, complaints, dates of dead-end flushing, and maintenance records; and 30 TAC §290.46(e) and (j), and Texas Health and Safety Code (THSC), §341.033(a), by failing to ensure that the facility was operated at all times under the direct supervision of a class D water works operator and by failing to ensure that a plumbing inspector or water supply protection specialist licensed

by the Texas State Board of Plumbing Examiners performed customer service inspections; PENALTY: $952; STAFF ATTORNEY: Rebecca Davis, Litigation Division, MC 175, (512) 239-5487; REGIONAL OFFICE: Corpus Christi Regional Office, 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(4) COMPANY: Don English dba English Acres; DOCKET NUMBER: 2004-0585-PWS-E; TCEQ ID NUMBERS: 1250033 and RN102670783; LOCATION: off of Highway 44 at the intersection of Farm-to-Market Road 1554 and County Road 136, west of Alice, Jim Wells County, Texas; TYPE OF FACILITY: public water system facility; RULES VIOLATED: 30 TAC §290.110(b)(4), by failing to maintain the residual disinfectant concentration in the far reaches of the distribution system at a minimum of 0.2 milligrams per liter (mg/L) free chlorine; 30 TAC §290.51(a)(3) and THSC, §341.041(a), by failing to pay public health service fees for the years 1994 - 2004 in the amount of $1,636.11; 30 TAC §290.117(c)(5), by failing to conduct lead and copper monitoring; 30 TAC §290.108(c), by failing to perform quarterly monitoring of radiological contaminants in 2003 and to report the results of the chemical analyses; 30 TAC §290.107(c)(1)(B) and (2)(B), by failing to perform annual monitoring of volatile organic compounds and synthetic organic contaminants and to report the results for these chemical analyses; and 30 TAC §290.106(c)(3)(A), by failing to perform monitoring of inorganic contaminants and to report the results for these chemical analyses; PENALTY: $3,575; STAFF ATTORNEY: Rebecca Davis, Litigation Division, MC 175, (512) 239-5487; REGIONAL OFFICE: Corpus Christi Regional Office, 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

TRD-200505446
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: November 22, 2005

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Notice of Opportunity to Comment on Settlement Agreements of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 2, 2006**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 2, 2006**. Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, §7.075 provides that comments on an AO should be submitted to the commission in **writing**.

(1) COMPANY: Chevron Phillips Chemical Company LP; DOCKET NUMBER: 2004-1533-AIR- E; TCEQ ID NUMBERS: JE0508W and RN100209857; LOCATION: 2001 Gulfway Drive, Port Arthur, Jefferson County, Texas; TYPE OF FACILITY: industrial organic chemical manufacturing plant; RULES VIOLATED: 40 Code of Federal Regulations (CFR) §§60.7(a)(3), 60.662, 60.665(a) and (l), 60.702, 60.705(a) and (l), 30 TAC §101.20(1), and §116.115(c); New Source Review (NSR) Air Permit Number 5215A, Special Condition 2A and 2C; NSR Air Permit Number 21101, Special Condition 1B and 1C; and Texas Health and Safety Code (THSC), §382.085(b), by failing to provide notification of startup, notification of specific provision applicability, or initial and periodic reports; 40 CFR §60.705(b) - (j), 30 TAC §101.20(1), and §116.115(c), NSR Air Permit Number 5215A, Special Condition 1B and 1C, and THSC, §382.085(b), by failing to keep up-to-date, readily accessible records; 40 CFR §60.18(b)(2), 30 TAC §101.20(1), and §116.115(c), NSR Air Permit Number 5215A, Special Condition 5, and THSC, §382.085(b), by failing to operate a flare with a pilot flame lit at all times; THSC, §382.085(a), by allowing unauthorized emissions; 30 TAC §106.454(3)(B)(i) and §115.412(1)(A), and THSC, §382.085(b), by failing to satisfy a permit by rule condition; 30 TAC §106.8(c) and THSC, §382.085(b), by failing to maintain, and make readily available for review, required records; 30 TAC §116.110(a), and THSC, §382.0518(a) and §382.085(a), by failing to obtain authorization for air emissions; 30 TAC §101.201(b)(1) - (3) and (8) and §101.211(b)(1) - (3) and (9), and THSC, §382.085(b), by failing to provide complete records of 72 nonreportable events and 40 maintenance activities that occurred from March 13, 2003 - August 31, 2004; and 30 TAC §116.115(b)(2)(F), NSR Air Permit Number 21101, Maximum Allowable Emission Rate Table, and THSC, §382.085(b), by causing, suffering, allowing, and/or permitting the unauthorized emissions; PENALTY: $278,250; STAFF ATTORNEY: Amie Richardson, Litigation Division, MC 175, (512) 239-2999; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(2) COMPANY: City of Coleman; DOCKET NUMBER: 2003-0347-MLM-E; TCEQ ID NUMBERS: CO-0003-M, RN102521994, 0420001, and RN102424645; LOCATION: 201 North Colorado Street and 800 Mississippi Street, Coleman, Coleman County, Texas; TYPE OF FACILITY: electric generation plant and water treatment plant; RULES VIOLATED: 30 TAC §122.146(2), Federal Operating Permit Number O-00102, Provision (b)(2), and THSC, §382.085(b), by failing to submit annual Title V permit compliance certification no later than 30 days after the end of the certification period; 30 TAC §122.504(a)(4)(A), Federal Operating Permit Number O-00102, Provision (b)(3), and THSC, §382.085(b), by failing to submit an updated general operating permit (GOP) application no later than 45 days after the issuance of the revised GOP; 30 TAC §290.42(d)(9)(A), by failing to operate parallel treatment facilities for flocculation; 30 TAC §290.46(m)(1)(A), by failing to maintain the exterior coating systems to adequately protect the metal surfaces of the 0.500 million gallon and 0.200 million gallon ground storage tanks; and 30 TAC §290.113(b)(1) and THSC, §341.0315(c), by exceeding the maximum contaminant level (MCL) based on a running annual average for total trihalomethanes (TTHM) during the second quarter of 2004; PENALTY: $9,115; STAFF ATTORNEY: Laurencia Fasoyiro, Litigation Division, MC R-12, (713) 422-8914; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(3) COMPANY: Daniel S. Boschert, Inc. dba Motor Street Mobil; DOCKET NUMBER: 2004- 1408-PST-E; TCEQ ID NUMBERS: 17523 and RN101537751; LOCATION: 2606 North Stemmons Freeway, Dallas, Dallas County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of its petroleum underground storage tanks (USTs); PENALTY: $4,280; STAFF ATTORNEY: Xavier Guerra, Litigation Division, MC R-13, (210) 403-4016; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: La Porte Methanol Company, L.P.; DOCKET NUMBER: 2004-1673-AIR-E; TCEQ ID NUMBERS: HX2302N and RN102830866; LOCATION: 11603 Strang Road, La Porte, Harris County, Texas; TYPE OF FACILITY: industrial organic chemicals manufacturing plant; RULES VIOLATED: 30 TAC §101.20(2) and §122.143(4), Air Permit Number 2291, Special Condition 6C, THSC, §382.085(b), and 40 CFR §63.6(e)(3)(i), by failing to develop, implement, and maintain a startup, shutdown, and malfunction plan for its hazardous organic National Emission Standards for Hazardous Air Pollutants (HON) sources; 30 TAC §101.20(2) and §122.143(4), Air Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.104(a) and (b)(1), by failing to conduct the required monthly monitoring of the HON heat exchange system; 30 TAC §101.20(2) and §122.143(4), Air Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.105(b) and (e), by failing to have a complete maintenance wastewater plan; 30 TAC §117.206(i) and §122.143(4), Permit Number 2291, Special Condition 10A, THSC, §382.085(b), by failing to comply with the operating restrictions for the Houston-Galveston ozone nonattainment area by starting and operating a stationary engine for testing or maintenance between the hours of 6:00 a.m. and 12:00 p.m.; 30 TAC §117.213(i), §117.219(f) and (6)(B), THSC, §382.085(b), by failing to record the operating run time and maintain other required records of weekly tests of the stationary gas turbine (PW453-50-0) for the period June 2, 2003 - January 2, 2004; 30 TAC §115.356(1) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), by failing to maintain complete records identifying each process unit subject to fugitive monitoring; 30 TAC §§101.20(2), 115.212(a)(6)(A), 115.216(1)(A)(ii), and 122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), 40 CFR §63.564(a)(2) and (h)(1), and §63.562(b)(2) and (e), by failing to monitor and record continuously the inlet and outlet temperatures of the vapor recovery/refrigeration system for the methanol barge loading during loading operations, and by failing to maintain the 97% recovery requirement in maximum achievable control technology (MACT) Subpart Y (40 CFR 63, Subpart Y) on the vapor recovery/refrigeration system for the methanol barge loading for the period of June 2, 2003 - February 27, 2004; 30 TAC §101.20(2) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.562(e)(2) and (5), by failing to develop and implement a written operation and maintenance plan for the marine loading operation; 30 TAC §115.112(a)(1) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), by failing to ensure all volatile organic compound (VOC) containers are capable of maintaining working pressure sufficient at all times to prevent any vapor or gas loss to the atmosphere or are equipped with an appropriate control device; 30 TAC §122.45(2), Permit Number 2291, General Conditions, THSC, §382.085(b), by failing to report four deviations no later than 30 days after the end of the reporting period; 30 TAC §§101.20(2), 115.352(1) and (2), 116.115(c), and 122.143(4), Permit Number 2291, Special Condition 12A, Permit Number 40938, Special Condition 21, THSC, §382.085(b), and 40 CFR §63.168, by failing to repair one valve (TAG Number 7302497) within 15 calendar days after the leak was found; 30 TAC §§101.20(2), 115.216(4)(B), and 122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.567(h) and (i), by failing to maintain records of the vapor tightness tests for each marine vessel loaded at the plant for at least two years; 30 TAC §101.20(2) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.562(e), by failing to operate and maintain a source of air emissions in a manner consistent with safety and good air pollution control practices; 30 TAC §101.20(2) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.567(e)(1) and (6), by failing to complete and submit periodic excess emission reports and compliance monitoring strategy performance and/or summary reports to the administrator for 2003; 30 TAC §101.20(2) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.567(j)(3), by failing to submit an annual report of hazardous air pollutants emissions (HAPS) and vapor collection system control efficiency for the period June 2, 2003 - June 2, 2004; 30 TAC §101.201(b), and §122.143(4), Permit Number 2291, Special Condition 2F, THSC, §382.085(b), by failing to create a final record of 14 non-reportable emission events within two weeks after the end of the events during the June 2, 2003 - June 2, 2004 reporting period; 30 TAC §101.20(2) and §122.143(4), Permit Number 2291, Special Condition 1C, THSC, §382.085(b), and 40 CFR §63.120(a)(5), by failing to notify the administrator in writing at least 30 calendar days prior to the filling of a degassed methanol tank SG112-1-1; 30 TAC §116.115(c) and §122.143(4), Permit Number 2291, Special Condition 12A, Permit Number 40938, Special Condition 1, and THSC, §382.085(b), by failing to meet the maximum allowable short-term emission rates for the marine loading dock when the maximum allowable loading rate of 1,500 gallons per minute (gpm) was exceeded for the period December 3, 2003 - August 18, 2004; and 30 TAC §122.210(a), THSC, §382.085(b), by failing to submit a Title V revision request to the TCEQ in order to add the high pressure flare (EPN: SG21-1-1) to the permit as back-up control for tank SG110-1-1; PENALTY: $66,990; STAFF ATTORNEY: Laurencia Fasoyiro, Litigation Division, MC R-12, (713) 422-8914; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(5) COMPANY: Lacefield Investments, Inc. dba Don's Port Marina; DOCKET NUMBER: 2005- 0195-PST-E; TCEQ ID NUMBERS: 47186 and RN101853364; LOCATION: 1937 Island Circle, Kemp, Henderson County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of its petroleum USTs; PENALTY: $2,100; STAFF ATTORNEY: Kathleen Decker, Litigation Division, MC 175, (512) 239-6500; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3756, (903) 535- 5100.

(6) COMPANY: Paco Steel Corp dba Best Pak Warehouse; DOCKET NUMBER: 2004-1029-PST- E; TCEQ ID NUMBERS: 74317 and RN100907260; LOCATION: 1415 East Loop North, Houston, Harris County, Texas; TYPE OF FACILITY: warehouse with gasoline refueling pump; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental release arising from the operation of a petroleum UST; and 30 TAC §334.22(a) and TWC, §5.702, by failing to pay petroleum storage tank (PST) fees as recorded in TCEQ Financial Account Number 0058052U; PENALTY: $1,050; STAFF

ATTORNEY: Deborah A. Bynum, Litigation Division, MC 175, (512) 239-1976; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: South Texas Chlorine, Inc.; DOCKET NUMBER: 2004-0142-MLM-E; TCEQ ID NUMBERS: CD-0085-I, TXRO5H669, and RN100943044; LOCATION: 8600 East Harrison, Harlingen, Cameron County, Texas; TYPE OF FACILITY: chemical repackaging plant; RULES VIOLATED: 30 TAC §116.115(c), THSC, §382.085(b), NSR Permit Number 21286, Special Condition Number 8, by failing to properly monitor the concentration of the scrubbing solution at least once per shift; 30 TAC §116.115(c), THSC, §382.085(b), NSR Permit Number 21286, Special Condition Number 25, by failing to maintain to maximum allowed bleach production limit of 120 batches per year; 30 TAC §116.115(c), THSC, §382.085(b), NSR Permit Number 21286, Special Condition Number 26(A), (D), and (F) - (H), by failing to meet the following recordkeeping requirements: 1) records of the railcar unloading operations; and 2) records of the results of the required fugitive monitoring and maintenance program; 30 TAC §281.25(a)(4), §335.4, multi-sector general permit (MSGP) Number TXRO5H669, Part III, Section A(3)(a) and (b), and TWC, §26.121, by failing to identify and obtain a permit for non-storm water discharge; 30 TAC §281.25(a)(4), and MSGP Number TXR05H669, Part III, Section A(4)(a) - (c), by failing to include the following items in the Storm Water Pollution Prevention Plan (SWP3): 1) the inventory of exposed materials, specifically storage of waste streams; 2) narrative description of all activities that could contribute pollutants to the storm water, specifically leaking waste streams from pumps and piping; and 3) two outfall locations on the site map; 30 TAC §281.25(a)(4), and MSGP Number TXR05H669, Part III, Section A(5)(b), (f), and (h), by failing to include a detailed description in the SWP3 of the following: 1) spill prevention and response measures where spills could contribute pollutants to storm water discharges; 2) an established training program for all employees responsible for implementing or maintaining the activities of the SWP3; and 3) a method to record the required information for the quarterly visual monitoring; and 30 TAC §335.62 and 40 CFR §262.11, by failing to complete a hazardous waste determination of the two wastewater streams generated as a result of the washing of compressed gas cylinders and the one-ton containers in the scrubber tanks; PENALTY: $5,100; STAFF ATTORNEY: Laurencia Fasoyiro, Litigation Division, MC R-12, (713) 422-8914; REGIONAL OFFICE: Harlingen Regional Office, 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(8) COMPANY: Steven and Sheila Agnew dba Heritage Oaks Subdivision; DOCKET NUMBER: 2004-0319-PWS-E; TCEQ ID NUMBERS: 1700121 and RN101248938; LOCATION: off of West Heritage Oaks Drive, Porter, Montgomery County, Texas; TYPE OF FACILITY: retail public water system; RULES VIOLATED: 30 TAC §290.42(e)(5), by failing to provide a housed and locked enclosure for the hypochlorinator solution container and pump; 30 TAC §290.46(m), by failing to implement appropriate maintenance and housekeeping practices to ensure the good working condition and general appearance of the facility and equipment; 30 TAC §290.45(b)(1)(C)(i) and THSC, §341.0315(c), by failing to meet the TCEQ minimum water system capacity requirements of a well capacity of 0.6 gallons per minute per connection; 30 TAC §290.45(b)(1)(C)(ii) and THSC, §341.0315(c), by failing to meet the TCEQ minimum water system capacity requirements of a ground storage tank capacity of 200 gallons per connection; 30 TAC §290.45(b)(1)(C)(iii) and THSC, §341.0315(c), by failing to meet the TCEQ minimum water system capacity requirements to provide two or more pumps with a total capacity of two gallons per minute per connection; and 30 TAC §291.93(3) and TWC, §13.139(d), by failing, upon reaching 85% of a well, storage, or pumping capacity, to submit a planning report addressing the areas of capacity concerns; PENALTY: $2,087; STAFF ATTORNEY: Lena Roberts, Litigation Division, MC 175, (512) 239-0019; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767- 3500.

TRD-200505447
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: November 22, 2005

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Notice of Public Meeting Concerning the Addition of the Former Tenaha Wood Treating Facility to the State Superfund Registry

Notice of public meeting on January 12, 2006, in Tenaha, Shelby County, Texas, concerning the former Tenaha Wood Treating facility (the site). The purpose of the meeting is to obtain public input and information concerning the proposal to add the former facility to the state registry of Superfund sites, and the identification of potentially responsible parties.

The Texas Commission on Environmental Quality (TCEQ or commission) is required under the Texas Solid Waste Disposal Act (the Act), Health and Safety Code, Chapter 361, as amended, to annually publish a state registry that identifies facilities that may constitute an imminent and substantial endangerment to public health and safety or the environment due to a release or threatened release of hazardous substances into the environment. The most recent registry listing of these facilities was published in the April 29, 2005, issue of the *Texas Register* (30 TexReg 2583).

In accordance with the Act, §361.184(a), the commission must publish a notice of intent to list a facility on the state registry of state Superfund sites in the *Texas Register* and in a newspaper of general circulation in the county in which the facility is located. The commission hereby gives notice that the commission's executive director has determined that the site is eligible for listing and that the executive director proposes to list the site on the state registry. The commission proposes a residential land use designation for the site. Determination of appropriate land use may impact the remedial investigation and remedial action for the site. The TCEQ is proposing a residential land use designation based on the existing land use of the property, as prescribed in 30 TAC Chapter 350, Texas Risk Reduction Program, under §350.53.

This publication also specifies the general nature of the potential endangerment to public health and safety or the environment as determined by information currently available to the executive director. This notice of intent to list this site was also published on December 1, 2005, in the *Timpson & Tenaha News* and on December 2, 2005, in *The Center Light & Champion*.

The site proposed for listing is the former Tenaha Wood Treating facility, located south of Tenaha's city limits at 275 County Road 4382 in Shelby County, Texas. The geographic coordinates of the site are Latitude 31 degrees 55 minutes 1 second North and Longitude 94 degrees 13 minutes 54 seconds West. The description of the site is based on information available at the time the site was evaluated with the Hazard Ranking System (HRS). The HRS is the principal screening guide used by the commission to evaluate potential, relative risk to public health and the environment from releases or threatened releases of hazardous substances. The site description may change as additional information is gathered on the sources and extent of contamination.

The site is a six-acre lumber treating facility where two residences are presently situated. Wood treating operations were conducted from 1980 to 1985.

Pentachlorophenol (PCP) was used in the wood preservation process until 1982. Chromated copper arsenate was used in the wood preservation process from 1982 until wood treating operations ceased in 1985. According to a United States Environmental Protection Agency (EPA) site inspection report from 1984, no diking structures or runoff control systems were in place to mitigate hazardous substance releases; and stained soils and areas void of vegetation were observed in the drainage pathways and treatment areas.

The substances generated by the wood treatment processes on site include arsenic, copper, chromium, PCP, and dioxins. Data collected for the purposes of the HRS evaluation revealed elevated levels of arsenic, chromium, PCP, and dioxins in on-site soils and along the overland drainage pathway. An intermittent tributary to Flat Fork Creek and a wetland downstream from the site have observed elevated levels of dioxins attributable to the former wood treating operations at this site.

A public meeting will be held January 12, 2006, at 7:00 p.m., at the Tenaha City Hall, located at 122 North Center, Tenaha, Texas. The purpose of this meeting is to obtain additional information regarding the site relative to its eligibility for listing on the state registry, identify additional potentially responsible parties, and obtain public input and information regarding the appropriate use of land on which the site is located. The public meeting will be legislative in nature and not a contested case hearing under the Texas Administrative Procedure Act, Texas Government Code, Chapter 2001.

All persons desiring to make comments may do so prior to or at the public meeting. All comments submitted prior to the public meeting must be received by 5:00 p.m., January 11, 2006. Comments should be sent to Omar Valdez, Project Manager, Texas Commission on Environmental Quality, Remediation Division, MC 136, P. O. Box 13087, Austin, Texas 78711-3087 or by facsimile at (512) 239-2303. The public comment period for this action will end at the close of the public meeting on January 12, 2006.

A portion of the record for this site, including documents pertinent to the executive director's determination of eligibility, is available for review during regular business hours at the Fannie Brown Booth Memorial Library, 619 Tenaha Street, Center, Texas, (936) 598-5522. Copies of the complete public record file may be obtained during regular business hours at the commission's Records Management Center, Records Customer Service, Building E, First Floor, 12100 Park 35 Circle, Austin, Texas 78753, (800) 633-9363 or (512) 239-2920. Photocopying of file information is subject to payment of a fee.

Parking is available on the east side of Building D, convenient to access ramps that are between Buildings D and E.

Information is also available regarding the state Superfund program on the TCEQ Web site at *http://www.tceq.state.tx.us/remediation/superfund/index.html*.

Persons who have special communication or other accommodation needs who are planning to attend the meeting should contact the agency at (800) 633-9363. Requests should be made as far in advance as possible.

For further information about this site or the public meeting, please call Crystal Taylor, TCEQ Community Relations, at (800) 633-9363, extension 3844.

TRD-200505421

Paul Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: November 22, 2005

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Notice of District Petition

Notices mailed November 16, 2005 through November 23, 2005:

TCEQ Docket No. 2005-1649-DIS; NOTICE OF DISTRICT HEARING; The Texas Commission on Environmental Quality (TCEQ) will conduct a hearing on an application (Application) for conversion of Smith County Water Control and Improvement District No. 1 (District) to Smith County Municipal Utility District No. 1. The Application filed with the TCEQ was in the form of a petition from the District's elected board of directors. The TCEQ will conduct this hearing under the authority of Chapters 49 and 54 of the Texas Water Code, Title 30, Chapter 293 of the Texas Administrative Code and the procedural rules of the TCEQ. The TCEQ will conduct the hearing at 9:30 a.m., Wednesday, February 22, 2006, Building E, Room 201S, 12100 Park 35 Circle, Austin, Texas. Persons with disabilities who plan to attend this hearing and who need special accommodations at the hearing should call the TCEQ Office of Public Assistance at 1-800-687-4040 or 1-800-RELAY-TX (TDD), at least one week prior to the hearing. The District was created on October 10, 1960 by TCEQ's predecessor agency, the State Board of Water Engineers, under the terms and provisions of Article XVI, Section 59 of the Texas Constitution and Chapter 3A of Title 128, Revised Civil Statutes of 1925. Under this law, the District was vested with the authority to operate as a water control and improvement district whose purpose is currently defined in Texas Water Code Chapter 51. The Application states that the District's purpose as a water control and improvement district limits the District's ability to serve the best interests of its citizens. A conversion to a municipal utility district operating under Texas Water Code Chapter 54 will expand the range of services the District can provide its citizens to include solid waste services which it is not authorized to provide as a water control and improvement district. The District has also stated that a conversion into a municipal utility district would serve the best interest of the district and would be a benefit to the land and property included in the district. The District serves 4,808 acres in Smith County.

TCEQ Internal Control No. 08042005-D04; BGM Land Investments, LTD. (Petitioner) filed a petition for creation of Harris County Municipal Utility District No. 439 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there is one lien holder, Southern National Bank of Texas, N.A., on the property to be included in the proposed District, and the Petitioner has provided the TCEQ with a certificate evidencing its consent to the creation of the proposed District; (3) the proposed District will contain approximately 314.7 acres located in Harris County, Texas; and (4) the proposed District is within the corporate boundaries of the City of Houston, Texas, and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. By Ordinance No. 2005-731 , effective June 14, 2005, the City of Houston, Texas, gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain and operate a waterworks and sanitary sewer system for municipal, domestic, industrial and commercial purposes; (2) acquire, construct, operate and maintain

a system to gather, conduct, divert, and control local storm water or other local harmful excesses of water within the District; (3) purchase, acquire, construct, own, lease, extend, improve, operate, maintain, and repair such additional improvements, facilities, plants, equipment, and appliances consistent with the purposes for which the District is organized, all as more particularly described in an engineer's report filed simultaneously with the filing of the petition. According to the petition, the Petitioner has conducted a preliminary investigation to determine the cost of the project, and from the information available at the time, the cost of the project is estimated to be approximately $16,100,000.

TCEQ Internal Control No. 09072005-D03; Moody Simmons 1463, Ltd (Petitioners) filed a petition for creation of Fort Bend County Municipal Utility District No. 161 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioners are the owner of a majority in value of the land to be included in the proposed District; (2) there is one lien holder, Bank of Texas, NA, on the property to be included in the proposed District; (3) the proposed District will contain approximately 211.2242 acres located within Fort Bend County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Katy, Texas (due to pending annexation the proposed District may be within the corporate limits of the City of Katy), and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. By Ordinance No. 2289, effective August 22, 2005, the City of Katy, Texas, gave its consent to the creation of the proposed District. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain and operate a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, maintain and operate works, improvements, facilities, plants, equipment and appliances helpful or necessary to provide more adequate drainage for the property in the proposed District; (3) control, abate and amend local storm waters or other harmful excesses of water; and (4) purchase, construct, acquire, improve, maintain, and operate additional facilities, systems, plants, and enterprises consistent with the purposes for which the District is created, all as more particularly described in an engineer's report filed simultaneously with the filing of the petition. According to the petition, the Petitioners have conducted a preliminary investigation to determine the cost of the project, and from the information available at the time, the cost of the project is estimated to be approximately $13,670,000.

TCEQ Internal Control No. 08152005-D01; Varner Creek Utility District of Brazoria County has applied to the Texas Commission on Environmental Quality (TCEQ) for authority to adopt and impose an annual uniform operations and maintenance standby fee up to $5 per equivalent single family connection per month for calendar years 2006-2008, on unimproved property within the District. The application was filed pursuant to Chapter 49 of the Texas Water Code, 30 Texas Administrative Code Chapter 293, and the procedural rules of the TCEQ. The TCEQ may approve the annual standby fee as requested, or it may approve a lower annual standby fee, but it shall not approve an annual standby fee greater than the amount requested. The standby fee is a personal obligation of the person owning the undeveloped property on January 1 of the year for which the fee is assessed. A person is not relieved of his pro-rated share of the standby fee obligation on transfer of title to the property. On January 1 of each year, a lien is attached to the undeveloped property to secure payment of any standby fee imposed and the interest or penalty, if any, on the fee. The lien has the same priority as a lien for taxes of the District. The purpose of standby fees is to distribute a fair portion of the cost burden for operations and maintenance costs and debt service of the District facilities to owners of property who have not constructed vertical improvements but have water, wastewater or drainage facilities or services available. Any revenues collected from the operations and maintenance standby fees shall be used to supplement the District's operations and maintenance account.

INFORMATION SECTION

The TCEQ may grant a contested case hearing on a petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed district's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below.

The Executive Director may approve a petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of the notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court.

Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team at 1-512-239-4691. Si desea información en Español, puede llamar al 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200505461
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 23, 2005

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Notice of Water Quality Applications

The following notices were issued during the period of November 16, 2005 through November 18, 2005.

The following require the applicants to publish notice in the newspaper. The public comment period, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P O Box 13087, Austin Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THIS NOTICE.

973 WASTEWATER COMPANY has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014642001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 950,000 gallons per day. The facility will be located 2,500 east of the intersection of Farm-to-Market Road 973 and New Sweden Church Road in Travis County, Texas.

CITY OF CAMPBELL has applied for a renewal of TPDES Permit No. 13791-001, which authorizes the discharge of treated domestic

wastewater at a daily average flow not to exceed 116,000 gallons per day. The facility is located adjacent to the northwest bank of Timber Creek, approximately 1000 feet south of State Highway 50; approximately 0.75 mile north of Interstate Highway 30; approximately 0.75 mile southwest of the northern intersection of State Highway 50 and Farm-to-Market 499 and approximately one mile southwest of the City of Campbell in Hunt County, Texas.

CITY OF COMO has applied for a renewal of TPDES Permit No. 11313-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day. The facility is located on the west side of Carroll Creek, approximately 2,400 feet west of the intersection of Farm-to-Market Road 69 and State Highway 11 in Hopkins County, Texas.

CITY OF DEL RIO has applied for a renewal of TPDES Permit No. WQ0010159001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 3,800,000 gallons per day. The facility is located approximately 3,500 feet southeast of the intersection of Hudson Street and Guyler Lane southeast of the City of Del Rio in Val Verde County, Texas.

CITY OF DIMMITT has applied for a renewal of Permit No. 10080-001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 0.75 million gallons per day via surface irrigation of 477 acres of non-public access agricultural land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located approximately one mile east of U.S. Highway 385 and 0.6 mile north of State Highway 86, northeast of the City of Dimmitt in Castro County, Texas.

EAST CENTRAL INDEPENDENT SCHOOL DISTRICT has applied for a renewal of TPDES Permit No. 13701-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 60,000 gallons per day. The facility is located approximately 2,300 feet north of the intersection of Sulphur Springs Road and Stuart Road and approximately 600 feet west of Stuart Road in Bexar County, Texas

LAKE TRAVIS INDEPENDENT SCHOOL DISTRICT has applied for a renewal of Permit No. 12920-002, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 6,700 gallons per day via subsurface disposal with pressure dosing to six evapotranspiration beds with a minimum area of 38,700 square feet. This permit will not authorize a discharge of pollutants into waters in the State. The facility and disposal site are located at 607 North Ranch Road 620, approximately 2.5 miles northeast of the intersection of Ranch Road 620 and Lohmann Ford Road in Travis County, Texas.

NORTHEAST TEXAS COMMUNITY COLLEGE has applied for a renewal of TPDES Permit No. 13948-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 10,000 gallons per day. The facility is located approximately 100 yards northwest of the campus entrance on Farm-to-Market Road 1735; approximately 3-1/2 miles southeast of the intersection of Farm-to-Market Road 1735 and State Highway 49 in Titus County, Texas.

NORTH ORANGE WATER & SEWER, LLC has applied for a renewal of TPDES Permit No. 11155-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 31,500 gallons per day. The facility is located on the east side of State Highway 87 approximately 3.0 miles north of the intersection of Interstate Highway 10 and State Highway 87 in Orange County, Texas.

CITY OF PALACIOS has applied for a renewal of TPDES Permit No. 10593-001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 800,000 gallons per day. The facility is located approximately 1,800 feet west of the intersection of 12th Street and Moiser Drive in Matagorda County, Texas.

TEXAS PARKS AND WILDLIFE has applied for a renewal of TPDES Permit No. 13613- 001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 40,000 gallons per day. The facility is located approximately 500 feet east of Buggy Whip Creek and approximately 7,800 feet north of Posey on State Highway 71 in Hopkins County, Texas.

CITY OF VERNON has applied for a renewal of TPDES Permit No. 10377-001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,000,000 gallons per day. The facility is located approximately 0.8 mile northeast of the intersection of U. S. Highway 283 and Fort Worth and Denver Railroad in the City of Vernon in Wilbarger County, Texas.

TRD-200505465
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 23, 2005

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Notice of Water Rights Application

Notice mailed November 22, 2005:

Application No. 5909; Energy Transfer Fuel, LP, 800 E. Sonterra Blvd., Suite 400, San Antonio, Texas 78258, applicant, seeks a temporary Water Use Permit, pursuant to Texas Water Code 11.138 and Texas Commission on Environmental Quality Rules 30 Texas Administrative Code (TAC) 295.1, et seq. Energy Transfer Fuel, LP seeks a temporary water use permit to divert 13.8 acre-feet of water within a period of one year from the Elm Fork Trinity River, tributary of the Trinity River, tributary of Trinity Bay, tributary of Galveston Bay, Trinity River Basin, at a maximum diversion rate of 6.68 cfs (3,000 gpm) for industrial purposes (hydrostatic test of pipeline) in Denton County. The diversion point is located at Latitude 33.31 N, Longitude 97.04 W, near the Elm Fork Trinity River crossing at FM 428, 8.3 miles northeast from the City of Denton and 3.8 miles west from Aubrey, a nearby town. The temporary permit, if issued, will be junior in priority to all senior and superior water rights in the Trinity River Basin. The Commission will review the application as submitted by the applicant and may or may not grant the application as requested. The application was received on July 8, 2005 and additional information and fees were received on September 6 and October 6, 2005. The application was declared administratively complete and filed with the Office of the Chief Clerk on October 19, 2005. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, by December 13, 2005.

INFORMATION SECTION

A public meeting is intended for the taking of public comment, and is not a contested case hearing.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any: (2) applicant's name and permit number; (3) the statement "[I/we] request a contested case hearing;" and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case

hearing must be submitted in writing to the TCEQ Office of the Chief Clerk at the address provided in the information section below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200505460
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 23, 2005

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Proposal for Decision

The State Office of Administrative Hearings issued a Proposal for Decision and Order to the Texas Commission on Environmental Quality on November 18, 2005, in the matter of the Executive Director of the Texas Commission on Environmental Quality, Petitioner v. Thomas J. Maloney; SOAH Docket No. 582-05-2955; TCEQ Docket No. 2003-0054-RAW- E. The commission will consider the Administrative Law Judge's Proposal for Decision and Order regarding the enforcement action against Thomas J. Maloney on a date and time to be determined by the Office of the Chief Clerk in Room 201S of Building E, 12100 N. Interstate 35, Austin, Texas. This posting is Notice of Opportunity to Comment on the Proposal for Decision and Order. The comment period will end 30 days from date of this publication. Written public comments should be submitted to the Office of the Chief Clerk, MC-105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. If you have any questions or need assistance, please contact Paul Munguía, Office of the Chief Clerk, (512) 239-3300.

TRD-200505466
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 23, 2005

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Proposed Enforcement Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075, which requires that the commission may not approve these AOs unless the public has been provided an opportunity to submit written comments. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 2, 2006**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withhold approval of an AO if a comment discloses facts or considerations that indicate the proposed AO is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code, the Texas Health and Safety Code (THSC), and/or the Texas Clean Air Act (the Act). Additional notice is not required if changes to an AO are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-1864 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P. O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 2, 2006**. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs should be submitted to the commission in **writing**.

(1) COMPANY: Aqua Utilities, Inc.; DOCKET NUMBER: 2005-1125-MWD-E; IDENTIFIER: Regulated Entity Reference Number (RN) 101513109; LOCATION: Rockwall, Rockwall County, Texas; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1) and (17), Texas Pollutant Discharge Elimination System (TPDES) Permit Number 11974001, and the Code, §26.121(a), by failing to comply with its permitted effluent limits for five-day biochemical oxygen demand, ammonia-nitrogen, and flow and by failing to submit monitoring results; PENALTY: $3,058; ENFORCEMENT COORDINATOR: Pamela Campbell, (512) 239-4493; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: Canyon Lake Water Supply Corporation; DOCKET NUMBER: 2005-1176- PWS-E; IDENTIFIER: RN101226678; LOCATION: New Braunfels, Comal County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and (5) and THSC, §341.0315(c), by exceeding the maximum contaminant level (MCL) for total trihalomethanes (TTHM) and haloacetic acids (HAA5); PENALTY: $1,310; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(3) COMPANY: Carbon Silica Partners, L.P. dba Diamond Fiberglass Fabricators; DOCKET NUMBER: 2005-1185-AIR-E; IDENTIFIER: RN100219443; LOCATION: Victoria, Victoria County, Texas; TYPE OF FACILITY: fiberglass manufacturing; RULE VIOLATED: 30 TAC §122.146(1) and (2) and §122.165(b) and (c), and THSC, §382.085(b), by failing to submit and complete an annual compliance certification; PENALTY: $1,800; ENFORCEMENT COORDINATOR: Daniel Siringi, (409) 898-3838; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(4) COMPANY: Exxon Mobil Corporation; DOCKET NUMBER: 2005-0993-AIR-E; IDENTIFIER: RN102579307; LOCATION: Baytown, Harris County, Texas; TYPE OF FACILITY: petroleum refinery; RULE VIOLATED: 30 TAC §101.20(1) and (3), §116.715(a), 40 Code of Federal Regulations (CFR) §60.104(a), Air Permit Number 18287/PSD-TX-730M3, and THSC, §382.085(b), by failing to prevent an avoidable emissions event; and 30 TAC §101.201(b)(8) and THSC, §382.085(b), by failing to include the authorization number on the final report; PENALTY: $28,900; ENFORCEMENT COORDINATOR: Miriam Hall, (512) 239-1044; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(5) COMPANY: Hill Sand Company, Inc.; DOCKET NUMBER: 2005-1267-WQ-E; IDENTIFIER: RN103872164; LOCATION: Houston, Harris County, Texas; TYPE OF FACILITY: sand mining; RULE VIOLATED: 30 TAC §305.125(1), TPDES Multi-Sector

General Permit Number TXR050000, and the Code, §26.121(a), by failing to comply with permit requirements by discharging water that is not eligible for coverage under the general permit; PENALTY: $6,280; ENFORCEMENT COORDINATOR: Catherine Albrecht, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(6) COMPANY: Innovene Polymers Inc.; DOCKET NUMBER: 2005-1213-AIR-E; IDENTIFIER: RN102537289; LOCATION: La Porte, Harris County, Texas; TYPE OF FACILITY: chemical manufacturing; RULE VIOLATED: 30 TAC §101.20(1), §116.715(a), Air Permit Number 28351, 40 CFR §60.18(c)(2), and THSC, §382.085(b), by failing to maintain the polypropylene flame; PENALTY: $7,500; ENFORCEMENT COORDINATOR: Rebecca Johnson, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: Invista S.A.R.L.; DOCKET NUMBER: 2005-0346-AIR-E; IDENTIFIER: RN102663671; LOCATION: Victoria, Victoria County, Texas; TYPE OF FACILITY: chemical manufacturing; RULE VIOLATED: 30 TAC §116.115(c), Permit Number 810A, and THSC, §382.085(b), by failing to prevent an unauthorized emission of carbon monoxide; and 30 TAC §101.201(a)(1) and THSC, §382.085(b), by failing to submit an initial notification within 24 hours after discovery of a reportable emissions event; PENALTY: $7,200; ENFORCEMENT COORDINATOR: Edward Moderow, (512) 239-2680; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(8) COMPANY: City of Jacksboro; DOCKET NUMBER: 2005-1329-PWS-E; IDENTIFIER: RN101401396; LOCATION: Jacksboro, Jack County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and THSC, §341.0315(c), by exceeding the MCL for TTHM; PENALTY: $645; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(9) COMPANY: City of Jasper; DOCKET NUMBER: 2005-1198-PWS-E; IDENTIFIER: RN101385250; LOCATION: Jasper, Jasper County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.46(q)(1), by failing to issue a boil water notice; PENALTY: $960; ENFORCEMENT COORDINATOR: Craig Fleming, (512) 239-5806; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(10) COMPANY: Lake Livingston Water Supply and Sewer Service Corporation; DOCKET NUMBER: 2005-1299-PWS-E; IDENTIFIER: RN101253904; LOCATION: near Livingston, Walker County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and (5) and THSC, §341.0315(c), by exceeding the MCL for TTHM and HAA5; PENALTY: $625; ENFORCEMENT COORDINATOR: Brent Hurta, (512) 239-6589; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(11) COMPANY: Meridian Precast & Granite, Inc.; DOCKET NUMBER: 2005-1090-WQ-E; IDENTIFIER: RN100594589; LOCATION: Waco, McLennan County, Texas; TYPE OF FACILITY: concrete, gypsum, and stone products; RULE VIOLATED: 30 TAC §281.25(a)(1) and 40 CFR §122.26(a), by failing to obtain an industrial general storm water permit; and the Code, §26.121(c), by failing to prevent the discharge of sediments into waters of the state; PENALTY: $1,664; ENFORCEMENT COORDINATOR: Pamela Campbell, (512) 239-4493; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(12) COMPANY: City of Point Comfort; DOCKET NUMBER: 2005-1259-PWS-E; IDENTIFIER: RN101391266; LOCATION: Point Comfort, Calhoun County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(5) and THSC, §341.0315(c), by exceeding the MCL for HAA5; PENALTY: $288; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5800; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(13) COMPANY: City of Rio Hondo; DOCKET NUMBER: 2005-1348-PWS-E; IDENTIFIER: RN101209195; LOCATION: Rio Hondo, Cameron County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.45(b)(2)(A) - (C) and (F) and THSC, §341.0315(c), by failing to meet a raw water pump capacity of 0.6 gallons per minute (gpm) per connection, by failing to meet the minimum water system capacity requirement of a total well rated well capacity of 0.6 gpm per connection, by failing to provide transfer pumps with a capacity of 0.6 gpm per connection, and by failing to provide a minimum capacity of two or more service pumps with a total capacity of two gpm per connection; 30 TAC §290.42(a) and THSC, §341.0315(c), by failing to provide a treatment plant capacity greater than its anticipated maximum daily demand; and 30 TAC §290.46(s)(1) and THSC, §341.0315(c), by failing to calibrate the flow measuring devices; PENALTY: $368; ENFORCEMENT COORDINATOR: Tel Croston, (512) 239-5717; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(14) COMPANY: City of Robstown Utility Systems; DOCKET NUMBER: 2005-1491-AIR-E; IDENTIFIER: RN100224203; LOCATION: Robstown, Nueces County, Texas; TYPE OF FACILITY: electrical general plant; RULE VIOLATED: 30 TAC §122.146(2) and THSC, §382.085(b), by failing to submit the annual compliance certification; PENALTY: $1,500; ENFORCEMENT COORDINATOR: Kimberly Morales, (713) 767-3500; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(15) COMPANY: Sebastian Municipal Utility District; DOCKET NUMBER: 2005-1358-PWS- E; IDENTIFIER: RN101193043; LOCATION: Sebastian, Willacy County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and (5) and THSC, §341.0315(c), by exceeding the MCL for TTHM and HAA5; PENALTY: $384; ENFORCEMENT COORDINATOR: Carolyn Lind, (903) 535-5100; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(16) COMPANY: Southwest Glass, Inc.; DOCKET NUMBER: 2005-1283-PST-E; IDENTIFIER: RN101553485; LOCATION: Dallas, Dallas County, Texas; TYPE OF FACILITY: maintenance; RULE VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance; 30 TAC §334.50(a)(1)(A) and the Code, §26.3475(c)(1), by failing to provide a release detection method capable of detecting a release from any port of the underground storage tank (UST) system; 30 TAC §334.8(c)(4)(A)(vi) and (B) and (5)(A)(i) and the Code, §26.3467(a), by failing to submit a completed UST registration and self-certification form and by failing to make available to a common carrier a valid, current delivery certificate; and 30 TAC §334.49(c)(4)(C) and the Code, §26.3475(d), by failing to inspect and test the cathodic protection system for operability and adequacy of protection; PENALTY: $12,400; ENFORCEMENT COORDINATOR: Deana Holland, (512) 239-2504; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(17) COMPANY: City of Taft; DOCKET NUMBER: 2005-1453-MSW-E; IDENTIFIER: RN104617352; LOCATION: Taft, San Patricio County, Texas; TYPE OF FACILITY: unauthorized municipal solid waste disposal site; RULE VIOLATED: 30 TAC §330.4(a),

by failing to obtain authorization prior to any activity of storage, processing, or disposal of municipal solid waste; PENALTY: $720; ENFORCEMENT COORDINATOR: Howard Willoughby, (361) 825-3100; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(18) COMPANY: Tristar Convenience Stores, Inc. dba Handi Plus 11; DOCKET NUMBER: 2005-1098-PST-E; IDENTIFIER: RN104529490; LOCATION: Tomball, Harris County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to monitor USTs for releases; 30 TAC §115.248(1) and THSC, §382.085(b), by failing to make each employee aware of the purposes and correct operation procedures of the Stage II equipment; and 30 TAC §115.242(3)(A) and THSC, §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition and free of defects; PENALTY: $3,600; ENFORCEMENT COORDINATOR: Chad Blevins, (512) 239-6017; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(19) COMPANY: Western Extrusions Corporation; DOCKET NUMBER: 2005-1697-AIR-E; IDENTIFIER: RN102590700; LOCATION: Carrollton, Dallas County, Texas; TYPE OF FACILITY: aluminum extrusion painting; RULE VIOLATED: 30 TAC §122.146(1) and (2) and THSC, §382.085(b), by failing to timely submit the annual permit compliance certification; PENALTY: $1,720; ENFORCEMENT COORDINATOR: Samuel Short, (512) 239-5363; REGIONAL OFFICE: 2301 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(20) COMPANY: Zapata County; DOCKET NUMBER: 2005-0811-PWS-E; IDENTIFIER: RN101198075; LOCATION: Zapata, Zapata County, Texas; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.113(f)(4) and (5) and THSC, §341.0315(c), by exceeding the MCL for TTHM and HAA5; PENALTY: $1,600; ENFORCEMENT COORDINATOR: Suzanne Walrath, (512) 239-2134; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

TRD-200505422
Paul C. Sarahan
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: November 22, 2005

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Department of State Health Services

Licensing Actions for Radioactive Materials

Figure

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Bellaire	Mammography & Ultrasound Specialist DBA Ultrasound Specialist	L05926	Bellaire	00	11/01/05
Denton	Rocky Mountain Medical Center LP DBA North Texas Hospital	L05936	Denton	00	11/01/05
Garland	Garland Cardiac Imaging LP	L05948	Garland	00	11/08/05
Kingwood	E+Pet Imaging XIV LP	L05901	Kingwood	00	11/10/05
Sugar Land	Sugarland Heart Center Inc.	L05921	Sugar Land	00	11/15/05
McKinney	McKinney Imaging Center	L05908	McKinney	00	11/07/05
Waco	Texas Oncology PA Cancer Care & Research Center	L05940	Waco	00	11/14/05
Throughout Tx	Tracerco/Synetix Services A Business Unit of Johnson Matthey Inc.	L03096	Houston	00	11/03/05

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Allen	Presbyterian Medical Center DBA Presbyterian Hospital of Allen	L05765	Allen	02	11/07/05
Amarillo	The Don & Sybil Harrington Cancer Center	L03053	Amarillo	35	11/01/05
Andrews	Andrews County Hospital District DBA Permian Regional Medical Center	L03158	Andrews	20	11/03/05
Austin	Austin Heart PA	L05580	Austin	11	11/09/05
Austin	Austin Heart PA	L04623	Austin	30	11/08/05
Austin	Austin Heart PA	L04623	Austin	31	11/09/05
Austin	Columbia St David's Healthcare System LP DBA South Austin Hospital	L03273	Austin	60	11/03/05
Austin	Columbia/St. David's Healthcare System LP DBA St. David's Medical Center	L00740	Austin	89	11/14/05
Austin	Daughters of Charity Health Srvcs of Austin DBA Seton Healthcare Network	L02896	Austin	85	11/07/05
Austin	Texas Cardiovascular Consultants PA	L05246	Austin	18	11/02/05
Brownwood	Brownwood Hospital LP DBA Brownwood Regional Medical Center	L02322	Brownwood	53	11/07/05
Brownwood	Brownwood Hospital LP DBA Brownwood Regional Medical Center	L02322	Brownwood	54	11/09/05
Bruni	COGEMA Mining Inc.	L03024	Bruni	08	10/31/05
College Station	Texas A&M University Environmental Health & Safety	L00448	College Station	124	11/04/05
Dallas	Cooper Medical Imaging LLP	L05138	Dallas	08	11/01/05
Dallas	Medical City Dallas Hospital DBA Medical City	L01976	Dallas	159	11/14/05
Dallas	Medical City Dallas Hospital DBA Medical City	L01976	Dallas	160	11/14/05
Dallas	Methodist Hospitals of Dallas Radiology Srvs	L00659	Dallas	46	11/08/05
Dallas	Texas Hematology/Oncology Center PA DBA Patients Comprehensive Cancer Center	L05397	Dallas	11	11/09/05
Dallas	Texas Hematology/Oncology Center PA DBA Patients Comprehensive Cancer Center	L05397	Dallas	12	11/15/05
Dallas	The University of Texas Southwestern Medical Center at Dallas	L00384	Dallas	90	11/10/05

AMENDMENTS TO EXISTING LICENSES ISSUED CONTINUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Deer Park	Hexion Specialty Chemicals Inc	L05323	Deer Park	02	11/03/05
Eagle Lake	Rice District Community Hospital DBA Rice Medical Center	L03408	Eagle Lake	13	11/04/05
El Paso	Providence Memorial Hospital	L02353	El Paso	85	11/02/05
Granbury	Granbury Hospital Corporation DBA Lake Granbury Medical	L02903	Granbury	27	11/08/05
Houston	Kelsey Seybold Clinic PA	L00391	Houston	58	11/08/05
Houston	Lyondell-Citgo Refining LP	L00187	Houston	56	11/15/05
Houston	Mallinckrodt Medical Inc	L03008	Houston	71	11/09/05
Houston	Memorial Hermann Hospital System Inc DBA Memorial Hermann Hospital	L00650	Houston	74	11/08/05
Houston	PetNet Houston LLC DBA PetNet Houston LLC	L05542	Houston	07	11/02/05
Houston	Texas Nuclear Imaging Inc DBA Excel Diagnostics Imaging Clinic Medical Center	L05009	Houston	26	11/01/05
Houston	The Methodist Hospital	L00457	Houston	138	11/10/05
Houston	The Pet Scan Center	L05411	Houston	08	11/03/05
Houston	University of Texas MD Anderson Cancer Center	L00466	Houston	101	11/10/05
La Grange	Austin Heart La Grange	L05516	La Grange	10	10/31/05
La Grange	Austin Heart La Grange	L05516	La Grange	11	11/07/05
Marble Falls	Austin Heart PA DBA Austin Heart Clinic Marble Falls	L05505	Marble Falls	11	10/31/05
Marble Falls	Austin Heart PA DBA Austin Heart Clinic Marble Falls	L05505	Marble Falls	12	11/09/05
Paris	Advanced Heart Care PA	L05290	Paris	12	11/08/05
Round Rock	Austin Heart PA DBA Austin Heart	L05456	Round Rock	14	11/09/05
San Antonio	Cardiology Clinic of San Antonio PA	L04489	San Antonio	32	11/14/05
San Antonio	Central Cardiovascular Institute of SA	L04892	San Antonio	12	11/10/05
San Antonio	Christus Santa Rosa Health Care	L02237	San Antonio	86	11/16/05
San Antonio	Heart Hospital of San Antonio LP DBA Texsan Heart Hospital	L05722	San Antonio	06	11/10/05
San Antonio	PetNet Pharmaceuticals Inc DBA PetNet San Antonio	L05569	San Antonio	08	11/01/05
San Antonio	South Texas Radiology Imaging Centers	L03518	San Antonio	48	11/08/05
San Antonio	South Texas Radiology Imaging Centers	L00325	San Antonio	141	11/08/05
San Antonio	VHS San Antonio Imaging Partners LP	L04506	San Antonio	47	11/02/05
San Antonio	VHS San Antonio Partners LP	L00455	San Antonio	148	11/01/05
San Marcos	Austin Heart PA DBA Austin Heart San Marcos	L05452	San Marcos	15	11/09/05
Sugar Land	Heart & Vascular Association of Houston PA	L05892	Sugar Land	01	11/10/05
Tyler	Nutech Inc	L04274	Tyler	52	11/03/05
Tyler	Tyler Pet Imaging Institute LP	L05476	Tyler	06	09/10/05
Waco	Providence Health Center	L01638	Waco	50	10/31/05
Webster	CHCA Clear Lake LP DBA Clear Lake Regional Medical Center	L01680	Webster	68	11/14/05
Woodlands	Pharmafontiers Corp	L05592	Woodlands	05	11/09/05
Throughout Tx	Gulf Coast Weld Spec	L05426	Beaumont	38	11/09/05
Throughout Tx	NDE Solutions LLC	L05879	Bryan	04	11/15/05
Throughout Tx	National Inspection Services LLC	L05930	Crowley	05	11/09/05
Throughout Tx	Alliance Imaging Inc	L05336	Dallas	09	11/14/05
Throughout Tx	JRJ Paving Inc	L05307	Dallas	04	11/04/05
Throughout Tx	GK Techstar LLC DBA Techstar	L05562	Deer Park	05	11/03/05

AMENDMENTS TO EXISTING LICENSES ISSUED CONTINUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout Tx	Biotech Pharmacy Incorporated	L05335	El Paso	12	11/01/05
Throughout Tx	Bonded Inspections Inc	L00693	Garland	72	11/04/05
Throughout Tx	Halliburton Energy Services Inc	L00442	Houston	105	11/08/05
Throughout Tx	Irisndt Inc	L04769	Houston	21	11/03/05
Throughout Tx	Petrochem Inspection Services Inc	L04460	Houston	66	11/02/05
Throughout Tx	Varco LP FKA Tuboscope Vetco International Inc	L00287	Houston	118	11/10/05
Throughout Tx	Perf-O-Log Inc	L05478	Iowa Colony	13	11/03/05
Throughout Tx	Non Destructive Inspection Corporation	L02712	Lake Jackson	123	11/01/05
Throughout Tx	Non Destructive Inspection Corporation	L02712	Lake Jackson	124	11/08/05
Throughout Tx	Gray Wireline Service Inc	L03541	Levelland	13	11/02/05
Throughout Tx	High Tech Testing Service Inc	L05021	Longview	54	11/04/05
Throughout Tx	Superior Energy LLC	L05540	Longview	07	11/03/05
Throughout Tx	Total Petrochemicals USA Inc	L03498	Port Arthur	22	11/08/05
Throughout Tx	Ludlum Measurements Inc	L01963	Sweetwater	75	11/03/05
Throughout Tx	Apex Geoscience Inc	L04929	Tyler	23	11/08/05
Throughout Tx	K & N Perforators Inc	L02300	Victoria	27	11/09/05

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Austin	Austin Heart PA	L04623	Austin	32	11/09/05
Garland	Baylor Medical Center at Garland	L01565	Garland	36	11/15/05
Gatesville	Coryell County Memorial Hospital Authority DBA Coryell Memorial Hospital	L02391	Gatesville	27	11/08/05
Huntsville	Huntsville Memorial Hospital	L02822	Huntsville	13	11/16/05
Mesquite	Saleem Mallick MD PA	L05132	Mesquite	11	11/02/05
Throughout Tx	Associated Testing Laboratories Inc	L01553	Houston	24	11/02/05

EXEMPTIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
San Antonio	Hector L. Navariz, M.D.	L04698	San Antonio		10/31/05

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of Title 25 Texas Administrative Code (TAC), Chapter 289 regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC, Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC, Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756-3189. For information call (512) 834-6688.

TRD-200505457
Cathy Campbell
General Counsel
Department of State Health Services
Filed: November 23, 2005

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Notice of an Agreed Order Issued on November 16, 2005, on Registrant Karnes County Hospital District, d/b/a Otto Kaiser Memorial Hospital

An Agreed Order is hereby issued by the Department of State Health Services (department) to Karnes County Hospital District, d/b/a Otto Kaiser Memorial Hospital (mammography systems M00732-000) of Kenedy. A total penalty of $15,000 shall be paid by registrant for violations of 25 Texas Administrative Code, Chapter 289. The registrant shall also comply with additional settlement agreement requirements.

A copy of all relevant material is available, by appointment, for public inspection at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200505456
Cathy Campbell
General Counsel
Department of State Health Services
Filed: November 23, 2005

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Notice of Intent to Revoke Certificates of Registration

Pursuant to 25 Texas Administrative Code, §289.205, the Department of State Health Services (department), filed complaints against the following x-ray machine or laser registrants: Osteopathic Medical Center of Texas, Fort Worth, M00500; Robert D. Crist, D.D.S., Henderson, R07289; Preston Forest Animal Clinic, Dallas, R11978; Gilberto Melendez, M.D., P.A., San Antonio, R16491; Medplex Mobile Radiology and EKG Inc., San Antonio, R19553; Casa Linda Dentistry, Dallas, R20309; Transitional Hospitals Corporation, Inc., Arlington, R20324; Jonathan W. Reeder, D.M.D., Sweeny, R21344; Camin Cargo Control Inc., Pasadena, R21732; Martin Evans, Americus, Georgia, R23864; Valley Orthopedic Associates Inc., Brownsville, R24431; Texas Clinic, New Braunfels, R25474; Network Cancer Care LP, Denton, R25653; Byroad Chiropractic, Frisco, R26128; Texas Family Medical Association, Austin, R26695; Joseph Edward Mechanik, D.P.M., Houston, R26744; Pasadena Rehab Center, Pasadena, R26749; Border Foods Inc., Deming, New Mexico, R27037; Texas State Healthcare Systems LLC, Garland, R28109; Southwest Health and Rehab, LLC, Carrollton, R28417; CHCA Mainland LP, Texas City, Z00287; University of Texas Health Center at Tyler, Tyler, Z01393; Laserwurx LLC, Nashville, Tennessee, Z01739.

The complaints allege that these registrants have failed to pay required annual fees. The department intends to revoke the certificates of registration; order the registrants to cease and desist use of radiation machine(s); order the registrants to divest themselves of such equipment; and order the registrants to present evidence satisfactory to the department that they have complied with the orders and the provisions of the Texas Health and Safety Code, Chapter 401. If the fee is paid within 30 days of the date of each complaint, the department will not issue an order.

This notice affords the opportunity to the registrants for a hearing to show cause why the certificates of registration should not be revoked. A written request for a hearing must be received by the department within 30 days from the date of service of the complaint to be valid. Such written request must be filed with Richard A. Ratliff, P.E., Radiation Program Officer, 1100 West 49th Street, Austin, Texas 78756-3189. Should no request for a public hearing be timely filed or if the fee is not paid, the certificates of registration will be revoked at the end of the 30-day period of notice.

A copy of all relevant material is available, by appointment, for public inspection at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200505459
Cathy Campbell
General Counsel
Department of State Health Services
Filed: November 23, 2005

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Notice of Intent to Revoke Radioactive Material Licenses

Pursuant to 25 Texas Administrative Code, §289.205, the Department of State Health Services (department), filed complaints against the following licensees: Vital Imaging Companies, Houston, L05405; and Gem Microelectronic Materials, LLC, Bryan, L05731.

The complaints allege that these licensees have failed to pay required annual fees. The department intends to revoke the radioactive material licenses; order the licensees to cease and desist use of such radioactive materials; order the licensees to divest themselves of the radioactive material; and order the licensees to present evidence satisfactory to the department that they have complied with the orders and the provisions of the Texas Health and Safety Code, Chapter 401. If the fee is paid within 30 days of the date of each complaint, the department will not issue an order.

This notice affords the opportunity to the licensees for a hearing to show cause why the radioactive material licenses should not be revoked. A written request for a hearing must be received by the department within 30 days from the date of service of the complaint to be valid. Such written request must be filed with Richard A. Ratliff, P.E., Radiation Program Officer, 1100 West 49th Street, Austin, Texas 78756-3189. Should no request for a public hearing be timely filed or if the fee is not paid, the radioactive material licenses will be revoked at the end of the 30-day period of notice.

A copy of all relevant material is available, by appointment, for public inspection at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200505458
Cathy Campbell
General Counsel
Department of State Health Services
Filed: November 23, 2005

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Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation on Registrant Island Dental Supply Co., Inc.

Notice is hereby given that the Department of State Health Services (department) issued a notice of violation and proposal to assess an administrative penalty to Island Dental Supply Co., Inc. (registrant R26297-000) of Arlington. A total penalty of $4,000 is proposed to be assessed to the registrant for alleged violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available, by appointment, for public inspection at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200505455
Cathy Campbell
General Counsel
Department of State Health Services
Filed: November 23, 2005

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University of Houston System

Notice of Request for Proposal

In compliance with Chapter 2254, Texas Government Code, the University of Houston System for and in behalf of University of Houston-Downtown ("UHD") furnishes this notice of request for proposal. The University of Houston-Downtown seeks proposals from a firm to provide consulting services to assist the Employment Services & Operations Department in performing a compensation study and in developing and implementing a new staff compensation plan. Interested parties are invited to express their interest and describe their capabilities on or before January 3, 2006.

The term of the contract is to begin on or about January 20, 2006 and end December 31, 2006. Further information can be obtained from Tomas Turrubiates, Compensation Manager, at (713) 221-8263. All proposals must be specific and must be responsive to the criteria set forth in this request.

INFORMATION ABOUT THE UNIVERSITY OF HOUSTON-DOWNTOWN: The University of Houston-Downtown ("UHD"), founded in 1974, is a public, urban university and a component institution of the University of Houston System that offers both undergraduate and a limited number of graduate academic degree programs. The campus is located in downtown Houston, the nation's fourth largest city. Since its founding in 1974, the university has more than doubled the size of its student population and increased the number of degree programs from one to over 40, including six graduate programs. UHD predicts a continued growth in its student body, thus increasing the need for more qualified faculty and staff employees. In order to attract and retain qualified employees, UHD must have a compensation plan that is based on current Position competencies and technologies, and be competitive in the Houston market. It is the policy of UHD to allocate funds for payment of wages and salaries in as fair and equitable a manner as possible. A concurrent objective is to establish proper internal relationships among Positions and to compensate as close as possible to the market rate, considering state funding appropriations and the state Position classification system and compensation plan. In order to stay competitive in the Houston Higher Education market, the University of Houston-Downtown desires to restructure its current compensation plan. The method of patch-working existing grades and evaluation points is not keeping pace with a growing Position market or the University's own development. UHD must undertake the task of developing a new and restructured compensation plan.

SCOPE OF WORK: These steps represent the general description of activities to be accomplished and results that must be achieved in order for the compensation study to be completed successfully and in recommending a compensation plan. Contractor is requested to identify other tasks and activities appropriate to develop a customized solution for the University of Houston-Downtown.

Phase I- Project Planning

During this phase of the project, Contractor will conduct interviews with key UHD management staff to discuss organizational goals and philosophy regarding compensation; identify problems to be addressed; review the project scope, milestones, deliverables and due dates; and assign responsibilities to project team members for project activities. Following the initial interview process, Contractor will work with UHD senior management to develop a compensation strategy that will support UHD organizational objectives, facilitate recruitment and retention of qualified personnel, respond to employee needs and expectations, and serve as the foundation for compensation and reward system design at UHD.

Phase II- Position Analysis and Preparation of Position Descriptions

a. Develop Position Analysis Questionnaire (JAQ). Contractor will develop a new form for collecting Position information. The JAQ must capture Position-oriented activities; employee-oriented activities (e.g. human behaviors and Position demands); work procedures, equipment, tools, and work aids; job environment; and Position requirements. The JAQ will be distributed to all UHD staff for completion by the employee and review by the employee's immediate supervisor for accuracy and completeness.

b. Organize Position Information. Contractor will coordinate with UHD compensation staff to review JAQs in order to organize Position information, identify core duties for each Position, and review Position titles providing for consolidation of Position hierarchies and titles as appropriate. Contractor may be requested to meet with managers and/or departmental staff to gather additional information or to develop a thorough understanding of the Position prior to preparing Position descriptions. Special attention must be given to adequately describe and price positions with specialized skills, such as information systems positions.

c. Prepare Position Descriptions. Based upon information collected during the Position analysis process, Contractor will prepare new Position descriptions for approximately 200 classifications.

Phase III- Develop and Implement Position Evaluation Methodology

Under our current compensation plan, UHD uses a point factor evaluation system based on several criteria that are each individually weighted based on the Position type. A similar evaluation system or some other method for grading positions is needed.

a. Develop a new Position Evaluation Methodology. Contractor will review the current Position evaluation methodology used by UHD, discuss other Position evaluation methods, and recommend a solution for the proper placement of UHD's positions into appropriate compensable levels consistent with UHD compensation philosophy.

b. Apply the Position Evaluation Methodology. The organization's leadership will review the alternative methodologies available and choose the method that best suits their procedural needs and administrative capabilities. Once the Position evaluation method is selected, Contractor will apply the Position evaluation method to all positions in order to determine the relative worth of one Position to another ensuring internal equity.

Phase IV- Perform Market Analysis

Contractor will use information obtained during the Position analysis process to compare UHD's benchmarked positions to the competitive marketplace using published survey data, including CUPA survey results. Contractor will be expected to identify up to three separate sources of data for benchmark positions and combine the individual survey results to develop market composites for base compensation and total cash compensation at the 25th, 50th, and 75th percentiles of the market. UHD understands that Contractor may make recommendations for compensation grade reassignments based on external equity considerations.

Phase V- Develop Salary Structure

Contractor will develop competitive grades and ranges for the affected UHD staff Positions.

Phase VI- Implementation and Maintenance

a. Impact Analysis. Consultant will coordinate with UHD compensation professionals to examine the salaries of current employees and identify remedies for any compensation levels that are inconsistent with the new system. Consultant will identify strategies for a smooth transition to the new compensation plan.

b. Address Supplemental (or Variable) Compensation Considerations. Consultant will assist UHD personnel to identify special duties, related but not required skills, licenses, certifications, special training, and educational accomplishments for certain positions or Position families that should be used to provide variable compensation to incumbent personnel or to facilitate Position progression.

c. Present Salary Administration Program to Administration. Consultant will document the final outcome of the compensation study and provide UHD management with a new staff compensation plan, including a Position analysis questionnaire, new Position descriptions, a new Position evaluation methodology, and new compensation grades and salary ranges.

d. Develop Compensation Policy and Procedures. Consultant will assist UHD compensation professionals to develop compensation policies, procedures and forms as appropriate to facilitate the effective implementation and ongoing maintenance of the new compensation plan.

e. Training. Consultant will train compensation professionals in the proper use and administration of the program. Consultant may be requested to assist UHD compensation professionals with training other University personnel involved in day-to-day administration of the plan.

f. Recommend an Automation Solution. UHD management intends to purchase a software package to automate the wage and salary administration process. Consultant will assist in the selection of an automated solution for maintaining Position descriptions; evaluating positions and assigning grades; weighting competencies for variable compensation; and updating evaluation criteria, compensation ranges, and other tasks associated with salary administration.

GENERAL INSTRUCTIONS: Submit one (1) original, four (4) paper copies of your proposal in a sealed envelope to: the Employment Services and Operations Department, c/o Ivonne Montalbano, University of Houston-Downtown, One Main Street, Suite 910-S, Houston, Texas 77002-1001. All proposals must be received no later than the date and time specified in paragraph one above. Proposals must include a detailed plan for accomplishing the services described in "Scope of Work" above. Prospective submitters are invited to provide a plan for accomplishing each phase of the project. Prospective submitters are required to submit an estimate of the total cost of the project, along with detailed information on hours and hourly rate associated with each phase of the project. Cost is an important consideration, but the selection will not be made on cost alone. Contractor's ability to understand the University's needs and to develop a tailored compensation plan in a timely manner will be heavily considered.

COMPLIANCE WITH RFP REQUIREMENTS: By submission of a proposal, a submitter agrees to be bound by the requirements set forth in this RFP. The University, at its sole discretion, may disqualify a proposal from consideration if the University determines a proposal is non-responsive and/or non-compliant, in whole or in part, with the requirements set forth in this RFP.

SIGNATURE, CERTIFICATION OF SUBMITTER: The original paper proposal must be signed and dated by a representative of the submitter who is authorized to bind the submitter to the terms and conditions contained in this RFP and to comply with the information submitted in the proposal. Each submitter certifies to both: (1) the completeness, veracity, and accuracy of the information provided in the proposal and (2) the authority of the individual whose signature appears on the proposal. Proposals submitted without the required signature shall be disqualified.

OWNERSHIP OF PROPOSALS: All proposals become the physical property of the University upon receipt.

USE, DISCLOSURE OF INFORMATION: Submitters acknowledge that the University is an agency of the State of Texas and is, therefore, required to comply with the Texas Public Information Act. If a proposal includes proprietary data, trade secrets, or information the submitter wishes to except from public disclosure, then the submitter must specifically label such data, secrets, or information as follows: "PRIVILEGED AND CONFIDENTIAL -- PROPRIETARY INFORMATION." To the extent permitted by law, information labeled by the submitter as proprietary will be used by the University only for purposes related to or arising out of the: (1) evaluation of proposals; (2) selection of a submitter pursuant to the RFP process; and (3) negotiation and execution of a Contract, if any, with the submitter selected.

RESCISSION OF PROPOSAL: A proposal can be withdrawn from consideration at any time prior to expiration of the deadline for pro-

posals set forth in paragraph one pursuant to a written request sent to the address under the General Instructions section noted above.

REQUEST FOR CLARIFICATION: The University reserves the right to request clarification of any information contained in a proposal.

ADDENDA TO THE RFP: Each submitter will be provided with copies of University-approved addenda, including amendments, if any, to the RFP. If and as necessary, as determined by the University, submitters will, in turn, be allowed time to revise or supply additional information in response to such addenda.

COMMUNICATIONS WITH UNIVERSITY PERSONNEL: Except as provided in this RFP and as is otherwise necessary for the conduct of ongoing University business operations, submitters are expressly and absolutely prohibited from engaging in communications with University personnel who are involved in any manner in the review and/or evaluation of the proposals; selection of a submitter; and/or negotiations or formalization of a contract. If any submitter engages in conduct or communications that the University determines are contrary to the prohibitions set forth in this section, the University may, at its sole discretion, disqualify the submitter and withdraw the submitter's proposal from consideration.

DISCUSSIONS WITH SUBMITTERS: The University may conduct discussions and/or negotiations with any submitter that appears to be eligible for award ("Eligible Submitter") pursuant to the selection criteria set forth in this RFP. In conducting discussions and/or negotiations, the University will not disclose information derived from proposals submitted by competing submitters, except as and if law requires disclosure.

SELECTION OF PROPOSER: The submitter selected for award will be the submitter whose proposal, as presented in response to this RFP and as determined by the University in accordance with the evaluation criteria set forth in this RFP, to be the most advantageous to the University. Submitters acknowledge that the University is not bound to accept the lowest-priced proposal.

EVALUATION OF PROPOSALS: Submission of a proposal indicates the submitter's acceptance of the evaluation process set forth in this RFP and the submitter's acknowledgement that subjective judgments must be made by the University in regard to the evaluation process.

CRITERIA FOR EVALUATION: Evaluation of proposals and award to the Selected Submitter will be based on the following factors, as weighted and listed as follows: (1) Five (5) or more years of compensation consulting experience addressing best practices in the area of total compensation and competencies. (2) Completeness of responses to the above parameters (Scope of Work, Deliverables, Objectives). Respondents shall address each to include an estimate of effort and a time line. (3) Three or more directly related references, including at least one from higher education. References shall include a point of contact and means thereof. (4) Estimate of cost(s). These are to be broken down into deliverable components. (5) Evidence statement regarding use of HUBS. and (6) The University may also consider other information it deems relevant to the selection of a consultant.

CONSIDERATION OF ADDITIONAL INFORMATION: The University reserves the right to ask for and consider any additional information deemed beneficial to the University in evaluation of the proposals.

TERMINATION: This Request for Proposal in no manner obligates the University of Houston-Downtown to the eventual purchase of any services described, implied or which may be proposed until confirmed by a written consultant contract. Progress towards this end is solely at the discretion of the University of Houston-Downtown and may be terminated without penalty or obligation at any time prior to the signing of a contract. The University of Houston-Downtown reserves the right to cancel this RFP at any time, for any reason and to reject any or all proposals.

TRD-200505443
Brian S. Nelson
Executive Director and Associate General Counsel
University of Houston System
Filed: November 22, 2005

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Texas Lottery Commission

Instant Game Number 630 "Pharaoh's Gold"

1.0 Name and Style of Game.

A. The name of Instant Game No. 630 is "PHARAOH'S GOLD". The play style is "key number match".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 630 shall be $3.00 per ticket.

1.2 Definitions in Instant Game No. 630.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49 and 50.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: 16 TAC GAME NO. 630 - 1.2D

Figure 1: GAME NO. 630 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
02	TWO
03	THR
04	FOR
05	FIV
06	SIX
07	SVN
08	EGT
09	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FON
15	FTN
16	SXT
17	SVT
18	EGN
19	NTN
20	TWY
21	TNE
22	TTW
23	TTH
24	TFR
25	TFV
26	TSX
27	TSV
28	TEI
29	TNI
30	THY
31	THO
32	THW
33	THT
34	THF
35	THV
36	THX
37	THS
38	THE
39	THN
40	FRY
41	FRO
42	FTW
43	FTE
44	FFR
45	FFV
46	FSX

47	FSV
48	FEI
49	FNI
50	FTY
01	
02	
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Figure 2:16 TAC GAME NO. 630 - 1.2E

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. These three (3) small letters are for validation purposes and cannot be used to play the game. The possible validation codes are:

Figure 2: GAME NO. 630 - 1.2E

CODE	PRIZE
THR	$3.00
FIV	$5.00
SVN	$7.00
TEN	$10.00

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $3.00, $5.00, $7.00 or $10.00.

H. Mid-Tier Prize - A prize of $30.00, $100 or $300.

I. High-Tier Prize - A prize of $3,000 or $35,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (630), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 125 within each pack. The format will be: 630-0000001-001.

L. Pack - A pack of "PHARAOH'S GOLD" Instant Game tickets contains 125 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket 001 and 001 will be on the front of the pack; the back of ticket 125 will be revealed on the back of the pack. All packs will be tightly shrink-wrapped. There will be no breaks between the tickets in a pack. Every other book will reverse i.e., reverse order will be: the back of ticket 001 will be shown on the front of the pack and the front of ticket 125 will be shown on the back of the pack.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "PHARAOH'S GOLD" Instant Game No. 630 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "PHARAOH'S GOLD" Instant Game is determined once the latex on the ticket is scratched off to expose 70 (seventy) Play Symbols. The player must scratch the PHARAOH'S NUMBERS play symbols to reveal 24 numbers. The player must scratch only the numbers on each of the three Pyramids that match the PHARAOH'S NUMBERS play symbols. Each PHARAOH'S NUMBER play symbol will appear only once in a PYRAMID, but may appear in more than one PYRAMID. If a player matches all the numbers on the same horizontal line on a single Pyramid, the player wins the prize amount shown directly to the right of that line. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 70 (seventy) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 70 (seventy) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 70 (seventy) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 70 (seventy) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets within a book will not have identical patterns.

B. Players can win up to three (3) times in this game.

C. Within each PYRAMID all numbers will be unique but numbers may duplicate between pyramids.

D. No duplicate numbers will appear in the PHARAOH'S NUMBERS play area.

E. Non-winning tickets will never reveal a horizontal line of matching numbers in one PYRAMID.

F. A near-win is defined as one (1) number short of completing a row across in one (1) PYRAMID. Excluding the top row of each PYRAMID, non-winning tickets will have at least one (1) near win per PYRAMID.

G. Winning tickets will contain at least one (1) near win in addition to winning configuration.

2.3 Procedure for Claiming Prizes.

A. To claim a "PHARAOH'S GOLD" Instant Game prize of $3.00, $5.00, $7.00, $10.00, $30.00, $100 or $300, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $30.00, $100 or $300 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "PHARAOH'S GOLD" Instant Game prize of $3,000 or $35,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "PHARAOH'S GOLD" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "PHARAOH'S GOLD" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "PHARAOH'S GOLD" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 6,000,000 tickets in the Instant Game No. 630. The approximate number and value of prizes in the game are as follows:

Figure 3:16 TAC GAME NO. 630 - 4.0

Figure 3: GAME NO. 630 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$3	528,000	11.36
$5	336,000	17.86
$7	240,000	25.00
$10	240,000	25.00
$30	96,000	62.50
$100	7,500	800.00
$300	1,950	3,076.92
$3,000	25	240,000.00
$35,000	7	857,142.86

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.14. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 630 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 630, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200505423
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: November 22, 2005

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Public Hearing

On December 19, 2005, at 10:00 a.m., a public hearing will be held to receive public comments regarding the repeal of Title 16, Part 9, Chapter 401, §§401.304, 401.305, 401.307, 401.308, 401.312 and 401.315, relating to On-Line Game Rules (General), "Lotto Texas" On-Line Game Rule, "Pick 3" On-Line Game Rule, "Cash Five" On-line Game Rule, "Texas Two Step" On-line Game, and "Mega Millions" On-Line Game Rule, respectively. The commission will also receive public comment on separate actions, including, proposed amendments to Title 16, Part 9, Chapter 401, §401.301 relating to General Definition, proposed new §401.304 relating to On-Line Game Rule, and proposed new §401.305 relating to "Lotto Texas" On-Line Game Rule. The hearing will be held at the Texas Lottery Commission, Commission Auditorium, First Floor, 611 E. Sixth Street, Austin, Texas 78701. Persons requiring any accommodation for a disability should notify Michelle Guerrero, Executive Assistant to the General Counsel, Texas Lottery Commission at (512) 344-5113 at least 72 hours prior to the public hearing.

TRD-200505441
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: November 22, 2005

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Texas Department of Public Safety

Notice of Public Hearing

The Texas Department of Public Safety, in accordance with the Administrative Procedures and Texas Register Act, Texas Government Code, §2001, et seq., and Texas Transportation Code, Chapter 644, is holding a public hearing on December 20, 2005, at 9:00 a.m., in the Texas Department of Public Safety, Texas Highway Patrol Division, Conference Room A, 5805 North Lamar, Austin, Texas.

The purpose of this hearing is to receive comments from all interested persons regarding adoption of the proposed amendments to Administrative Rules §§4.1, 4.11-4.13, 4.16, and 4.17 regarding Hazardous Material and Transportation Safety, proposed for adoption under the authority of Texas Transportation Code, Chapter 644, which provides that the director shall, after notice and a public hearing, adopt rules regulating the safe operation of commercial motor vehicles. The proposed rules were published in the November 18, 2005, issue of the *Texas Register* (30 TexReg 7692 - 7701).

Persons interested in attending this hearing are encouraged to submit advance written notice of their intent to attend the hearing and to submit

a written copy of their comments. Correspondence should be addressed to Major Mark Rogers, Texas Highway Patrol Division, Texas Department of Public Safety, P. O. Box 4087, Austin, Texas 78773-0500.

Persons with disabilities who plan to attend this hearing and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print, or Braille, are requested to contact Major Rogers at (512) 424-2116, three working days prior to the hearing so that appropriate arrangements can be made.

TRD-200505420
Thomas A. Davis, Jr.
Director
Texas Department of Public Safety
Filed: November 21, 2005

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Public Utility Commission of Texas

Notice of Application for a Certificate of Convenience and Necessity for Service Area Boundary Exception within Uvalde County

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application filed on November 17, 2005, for service area boundary amendment within Uvalde County, Texas.

Docket Style and Number: Joint Application of Medina Electric Cooperative, Inc. and AEP Texas Central Company for a Certificate of Convenience and Necessity for Service Area Boundary within Uvalde County. Docket Number 32047.

The Application: Medina Electric Cooperative, Inc. (MEC) and AEP Texas Central Company (TCC) have agreed to a service area boundary amendment to allow MEC to provide service to a customer. Both companies have facilities in the general area that are capable of providing service to the anticipated new loads; however, MEC's facilities are positioned to provide a more desirable route to serve the customer. TCC has agreed to the proposed boundary exception.

Persons wishing to comment on the action sought or intervene should contact the Public Utility Commission of Texas no later than December 12, 2005 by mail at P. O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 32047.

TRD-200505451
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 22, 2005

♦ ♦ ♦

Public Notice of Application for Authority to Surcharge Fuel Under-recoveries

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application filed on November 1, 2005, for authority to surcharge fuel under-recoveries.

Docket Style and Number: Application of Southwestern Public Service Company for Authority to Surcharge its Fuel Under-Recoveries. Docket Number 31978.

The Application: Southwestern Public Service Company (SPS), doing business as Xcel Energy, filed with the commission an application for authority to surcharge its actual fuel under-recovery, and related interest, for the period of October 2004 through September 2005. In accordance with the commission's Substantive Rule §25.237, SPS proposes either to surcharge $104,049,659.61 and related interest or $79,130,269.94 and related interest depending on the outcome of SPS's fuel reconciliation covering the period 2002-2003, over a 12-month period beginning January 2006. A typical residential customer using 1,000 kWh per month would see an approximate increase of 9.7% or 7.5%, respectively during the summer months and 10.2% or 7.9%, respectively in the winter months, or $8.95 or $6.95, respectively on average per month, in his/her electric bill if the proposed surcharge factor is approved.

All classes of SPS's Texas retail customers will be affected by the proposed surcharge, which will become effective beginning January 2006 and remain in effect through December 2006. These charges will be subject to final review by the commission in a future fuel reconciliation proceeding.

Persons with questions or who want more information on this petition may contact Southwestern Public Service Company at 600 S. Tyler Street, Suite 2400, Amarillo, Texas 79101, or call 1-800-895-4999 during normal business hours. A complete copy of this petition is available for inspection at the address listed above or at the commission's central records division under Docket No. 31978. Persons who wish to intervene in the proceeding or comment upon the action sought should contact the Public Utility Commission of Texas, P. O. Box 13326, Austin, Texas 78711-3326 or call the commission's Office of Consumer Affairs at (512) 936-7120 or (888) 782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All correspondence should reference Docket Number 31978.

TRD-200505325
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 17, 2005

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Notice of Application for a Certificate to Provide Retail Electric Service

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on November 18, 2005, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA). A summary of the application follows.

Docket Title and Number: Application of Liberty Power Texas LLC for Retail Electric Provider (REP) certification, Docket Number 32053 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the service area of specific transmission and distribution utilities and/or municipal utilities or electric cooperatives in which competition is offered, as follows: CenterPoint, TXU, AEP, AEP North, TXNP.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than December 9, 2005. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 32053.

TRD-200505452
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 22, 2005

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Notice of Application for Relinquishment of a Service Provider Certificate of Operating Authority

On November 15, 2005, CoreComm filed an application with the Public Utility Commission of Texas (commission) to relinquish its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60024. Applicant intends to relinquish its certificate.

The Application: Application of CoreComm to Relinquish its Service Provider Certificate of Operating Authority, Docket Number 32040.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P. O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than December 7, 2005. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 32040.

TRD-200505321
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 17, 2005

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Notice of Application for Service Provider Certificate of Operating Authority

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on November 16, 2005, for a service provider certificate of operating authority (SPCOA), pursuant to §§54.151 - 54.156 of the Public Utility Regulatory Act (PURA). A summary of the application follows.

Docket Title and Number: Application of CloseCall America, Inc. for a Service Provider Certificate of Operating Authority, Docket Number 32043 before the Public Utility Commission of Texas.

Applicant intends to provide plain old telephone service, ADSL, ISDN, SDSL, T1-Private Line, Switch 56 KBPS, Fractional T1, long distance, wireless, and Voice Over IP services.

Applicant's requested SPCOA geographic area includes the entire State of Texas.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than December 7, 2005. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 32043.

TRD-200505449
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 22, 2005

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Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application filed on November 21, 2005, for an amendment to certificated service area boundaries within Cameron County, Texas.

Docket Style and Number: Application of the Brownsville Public Utilities Board (BPUB) to Amend a Certificate of Convenience and Necessity for Service Area Boundaries within Cameron County (Lago Vista Subdivision). Docket Number 32061.

The Application: The application encompasses an area of land which is singly certificated to American Electric Power Company (AEP), formerly known as Central Power & Light (CP&L), and is within the corporate limits of the City of Brownsville. BPUB received a letter request from Cardenas Development Company requesting BPUB to provide electric utility service to a proposed subdivision. The property encompasses 516.044 acres of land. The estimated cost to BPUB to provide service to this proposed area is $2,254,950.00. The area is presently undeveloped. If the application is granted, the area would be dually certificated for electric service.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than December 12, 2005, by mail at P. O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 32061.

TRD-200505454
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 22, 2005

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Notice of Intent to File LRIC Study Pursuant to P.U.C. Substantive Rule §26.215

Notice is given to the public of the filing on November 18, 2005, with the Public Utility Commission of Texas (commission), a notice of intent to file a long run incremental cost (LRIC) study pursuant to P.U.C. Substantive Rule 26.215. The Applicant will file the LRIC study on November 30, 2005.

Docket Title and Number: Application of Southwestern Bell Telephone Company, L.P. d/b/a SBC Texas for Approval of LRIC Study For Easy Access Dialing Change Charge (Local Presubscribed Interexchange Carrier (LPIC) Change Charge) Pursuant to P.U.C. Substantive Rule 26.215, Docket Number 32056.

Any party that demonstrates a justiciable interest may file with the administrative law judge, written comments or recommendations concerning the LRIC study referencing Docket Number 32056. Written comments or recommendations should be filed no later than forty-five (45) days after the date of a sufficient study and should be filed at the Public Utility Commission of Texas, by mail at P.O. Box 13326, Austin, Texas, 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free 1-800-735-2989. All comments should reference Docket Number 32056.

TRD-200505450
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: November 22, 2005

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Texas Office of State-Federal Relations

Notice of Contract Award

Notice of Award: Pursuant to Chapter 2254, Subchapter B, Texas Government Code, the Texas Office of State-Federal Relations (OSFR) announces this notice of consulting contract award.

The notice of request for proposals (RFP #333-0607-1000 and #333-0607-1001) was published in the July 15, 2005, issue of the *Texas Register* at 30 TexReg 4157.

The consultant(s) will assist OSFR in state-federal liaison activities in Washington, D.C.

The first contract (RFP #333-0607-1000) was awarded to Federalist Group, L.L.C., 1331 H Street, NW, Washington, DC 20005. The total amount of this contract is not to exceed $220,000.00.

The second contract (RPF #333-0607-1001) was awarded to Cassidy and Associates, 700 13th Street, Suite 400, Washington, DC 20005. The total amount of this contract is not to exceed $330,000.00.

The term of both contracts are November 16, 2005 through August 31, 2007.

TRD-200505419
Tony Gilman
Austin Director
Texas Office of State-Federal Relations
Filed: November 21, 2005

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Texas Department of Transportation

Public Notice - Aviation

Pursuant to Transportation Code, §21.111, and Title 43, Texas Administrative Code, §30.209, the Texas Department of Transportation conducts public hearings to receive comments from interested parties concerning proposed approval of various aviation projects.

For information regarding actions and times for aviation public hearings, please go to the following web site: **http://www.dot.state.tx.us**. Click on Aviation, then click on Aviation Public Hearing. Or, contact Joyce Moulton, Aviation Division, 150 East Riverside, Austin, Texas 78704, (512) 416-4501 or 800-68-PILOT.

TRD-200505322
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Filed: November 17, 2005

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Request for Proposals for Traffic Safety Program

In accordance with 43 TAC §25.901, et seq., the Texas Department of Transportation (TxDOT) is requesting project proposals to support the goals and strategies of a traffic safety program to reduce the number of motor vehicle related crashes, injuries and fatalities in Texas. These goals and strategies form the basis for the Fiscal Year 2007 (FY07) Highway Safety Performance Plan (HSPP).

The authority and responsibility of the traffic safety grant program derives from the National Highway Safety Act of 1966 (23 USC §401, et seq.), and the Texas Traffic Safety Act of 1967 (Transportation Code, Chapter 723). Traffic Safety is an integral part of the Texas Department of Transportation and works through the department's 25 districts for local projects. The program is administered at the state level by the department's Traffic Operations Division. The executive director of the department is the designated Governor's Highway Safety Representative.

The following are the 2007 HSPP Program Areas for which projects may be submitted: Planning and Administration; Alcohol and Other Drug Countermeasures; Emergency Medical Services; Motorcycle Safety; Occupant Protection, Pedestrian/Bicycle Safety; Police Traffic Services; Speed Control; Traffic Records; Driver Education and Behavior; Railroad/Highway Crossing; Roadway Safety; Safe Communities; and School Bus. Eligible organizations are state and local governments, educational institutions, and non-profit organizations.

The Request for Proposals for Fiscal Year 2007, current project proposal application forms and instructions, scoring criteria, and other related documents are available at the following location:

http://www.dot.state.tx.us/trafficsafety/grants/webrfpmenu.htm

If you have questions please contact Ms. Susan Warren at (512) 416-3177 or at swarre1@dot.state.tx.us in the TxDOT Traffic Operations Division, Traffic Safety Section. Proposals must be received by TxDOT no later than **5 p.m., February 1, 2006. Proposals received after this due date will not be accepted.**

TRD-200505445
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Filed: November 22, 2005

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How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 30 (2005) is cited as follows: 30 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "30 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 30 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 21, April 15, July 8, and October 7, 2005). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).